INTESA SANPAOLO RBM SALUTE

Insurance contract covering health costs

PID - Non-Life Product Information Document

Company: INTESA SANPAOLO RBM SALUTE S.p.A. – General Management in Italy – Company registered under number 1.00161 in the Register of Insurance Companies

Product: UNICA DIPENDENTI_EXTRA

Full pre-contractual and contractual information on the product is provided in other documents.

What kind of insurance is it?

The cover provides for the payment of expenses incurred as a result of an accident or illness for in-patient services, specialist and/or out-patient out-of-hospital services, ancillary benefits and prevention.

What is covered by the insurance?

The Company shall pay the following expenses:

- ✓ Surgical/Non-surgical medical expenses, surgical/non-surgical Same-Day hospitalisation, outpatient surgical procedure, Childbirth/therapeutic abortion, dental surgery, Major Surgery (MS), Transplantation, Post-surgical Rehabilitation, Major Morbid Events (MME);
- ✓ Indemnity in lieu for surgical/non-surgical hospitalisation: the Company shall pay indemnity in lieu for each day of hospitalisation;
- ✓ Newborns: the payment of expenses incurred for treatment and surgery resulting from malformations and/or physical defects;
- ✓ Highly Specialised Care and Diagnostics: the Company shall pay the expenses for a list of highly specialised services, therapies pertaining to oncological pathologies, endoscopic therapies and examinations;
- ✓ Non-invasive prenatal genetic testing on foetal DNA;
- ✓ Routine Diagnostics and Specialist Visits: the Company shall pay the expenses for analyses and diagnostic examinations and medical fees for specialist visits;
- ✓ Oncological care: the Company shall pay expenses for home nursing care, chemotherapy, radiation therapy, other therapies aimed at oncological treatments and specialist visits;
- ✓ Physical therapy benefits: the Company shall pay physical therapy expenses following a list of medical conditions;
- ✓ Speech therapy: the Company shall pay expenses for speech therapy following an accident;
- ✓ Specific learning disorders (SLD)
- ✓ Orthopaedic implants and hearing aids are eligible for payment of expenses incurred for the purchase, repair and replacement of orthopaedic implants and hearing aids;
- ✓ Dental care due to accidents;
- ✓ Additional benefits: the Company shall pay the expenses for paediatric medical visits;
- ✓ Lenses: the cover applies to the purchase of lenses and eyeglasses (including frames) or corrective contact lenses as a result of a change in visual acuity;
- ✓ Maternity package: expenses incurred for visits and check-ups shall be paid;
- ✓ Psychotherapy;
- ✓ Emergency Room Care;

See next page

What is not covered by the insurance?

- × New insured who have already reached the age of 85 on 31 December 2021 are not permitted to join the policy. However, individuals who were already covered under the previous health plan and who turn 85 during the term of the contract may continue to be insured until 31 December 2023.
- × Insurance cover does not apply in other cases, such as:
  - accidents resulting from the practice of air sports and from participation in professional competitions and related training,
  - accidents, illnesses and intoxications resulting from alcoholism, abuse of psychotropic drugs, and use of narcotics (except for therapeutic administration) or hallucinogens.
  - expenses incurred for a series of medical services (including non-therapeutic voluntary abortion) or due to treatment and procedures for the consequences or complications of accidents or illnesses that are not covered under the policy.

Are there any cover limits?

- ! Cover provides for specific deductibles and coinsurance per benefit, which may result in the reduction or non-payment of compensation.

INTESA SANPAOLO RBM SALUTE

What is covered by the insurance?

The Company shall pay the following expenses:

- ✓ Treatment of drug addicts;
- ✓ Nursing care;
- ✓ Repatriation of body;
- ✓ Home hospitalisation;
- ✓ Assisted reproductive technology;
- ✓ Postnatal care: Postpartum psychological support, lower limbs control and wellness weekend;
- ✓ Spa treatments for minors;
- ✓ Down Syndrome;
- ✓ Health Account;
- ✓ Indemnity for health and care costs incurred for parents hosted in a nursing home;
- ✓ Expenses for check-ups, Herpes Zoster Prevention, Heterologous Fertilisation, paediatric check-ups, nutritional consult and personalised diet and stem cell preservation.

The cover provides for a maximum annual limit (ceiling) of the indemnities recognised by the single benefits.

Where is the cover valid?

- ✓ The whole world. Damages are liquidated in Italy, in EUR. For expenses incurred abroad, reimbursements are made at the average exchange rate for the week in which the expense was incurred, as calculated from the ECB quotation.

What are my obligations?

- The Insured must make accurate and complete statements on the risk to be insured without reticence; during the course of the contract, they must report any changes that may lead to an increase in the insured risk. Failure to comply with these obligations may result in the complete or partial forfeiture of the indemnity and in the termination of the insurance
- The Insured or his/her assignees must report the Claim to the Company as soon as they are able. Failure to comply with this obligation may result in the complete or partial forfeiture of the right to the repayment of expenses.
- If the Insured is reimbursed by Funds or Entities, s/he must send the documentation of liquidation of such Entities together with photocopies of the relative invoices
- In order to obtain the settlement of claims, it is necessary to present the medical documentation with the diagnosis in the name of the Insured.
- In the event of an accident, if a third party is liable for the damaging event, the Insured shall notify the Company of the name and address of the liable third party and to end the report from the Emergency Room.
- In the event of a road accident, when filing the first payment claim regarding medical services, the Insured is required to send the Company the accident report drawn up by the police or the CID Form (amicable accident report).
- If the Insured Person wishes to use an affiliated facility, or an affiliated doctor or dentist, s/he shall always use the direct care scheme.

When and how should I pay?

- The premium is annual and indivisible but it is divided into monthly instalments in advance as shown on the policy certificate.
- The Policyholder shall pay the premium to the Company by bank transfer.

When does cover begin and when does it end?

- Cover lasts 2 years; it shall take effect at 0:00 am on 01/01/2022 if the premium or the first premium instalment has been paid; otherwise it shall take effect at midnight on the day after payment. it expires at midnight on 31/12/2023.

How can I cancel my policy?

- This cover is not tacitly extended and, therefore, is automatically terminated upon its natural expiry.
- There are cases in which the Policyholder has the right to withdraw from the contract.

Insurance covering medical expenses

Additional product information document for non-life insurance products (Additional Non-Life PID)

Intesa Sanpaolo RBM Salute S.p.A.

Product: UNICA DIPENDENTI_EXTRA

Last release 01/2022

This document contains additional and complementary information to that contained in the product information document for non-life insurance products (Non-life PID), in order to help the potential policyholder to understand in more detail the characteristics of the product, the contractual obligations and the financial situation of the Intesa Sanpaolo RBM Salute.

The policyholder must read the insurance conditions before signing the contract.

Intesa Sanpaolo RBM Salute S.p.A.
Registered office: via A. Lazzari no. 5, 30174 Venice – Mestre (VE)
tel. +39 041 2518798
Internet website: www.intesasanpaolorbmsalute.com;
e-mail: info@intesasanpaolorbmsalute.com; certified e-mail: comunicazioni@pec.intesasanpaolorbmsalute.com
Authorised to carry out insurance business by ISVAP Order no. 2556.
Subject to the management and coordination of Intesa Sanpaolo Vita S.p.A., entered in the Register of Insurance and Reinsurance Companies under no. 1.00161 and belonging to the Intesa Sanpaolo Vita Insurance Group, entered in the Register of Insurance Groups under no. 28.

Financial data at 31 December 2020

Shareholders' Equity: 367,891,567.00 euros, of which Share Capital 160,000,000.00 euros.
Total equity reserves: 146,026,695.00 euros.
The financial data (shareholders' equity, share capital, reserves and solvency ratio) are updated annually following the approval of the financial statements. They can be consulted at www.intesasanpaolorbmsalute.com (Corporate Information section).
Risk profiling results of Intesa Sanpaolo RBM Salute:

- Solvency Capital Requirement (SCR) = 143,283,029 euros
- Minimum Capital Requirement (MCR) = 35,820,757 euros
- Own funds eligible to cover SCR = 387,030,759 euros
- Own funds eligible to cover the MCR = 387,030,759 euros
- *Solvency ratio*: 270%

The contract shall be governed by Italian law.

What is covered by the insurance?

There is no additional information to that provided in the PID; the commitment of Intesa Sanpaolo RBM Salute is commensurate to the insured sums agreed with the policyholder.

What is NOT covered by the insurance?

Excluded risks	The following expenses are excluded from payment: 1) relating to the correction or elimination of myopia, except as provided for under section A "Hospitalisation", letter A), item 9 2) dentures, paradontopathies, dental treatments and dental examinations, except as provided for under section A "Hospitalisation", letter A), item 8 and under section B "Specialist and/or outpatient out-of-hospital care area", letter H

	3) medical services for aesthetic purposes, except for the following plastic surgery procedures: • surgery, including cosmetic surgery, for children under the age of three; • surgery following an accident eligible for compensation under the policy; • reconstructive surgery following demolitive procedures or cancer surgery (limited to the anatomical site of injury) eligible for compensation under the policy; • contralateral adjustment procedures related to reconstructive surgery following mastectomy or quadrantectomy under the sub-ceiling provided for under section A "Hospitalisation", letter A), item 10 4) hospitalisation during which only physical examinations or therapies, which, due to their technical nature, can also be carried out in an outpatient clinic, are carried out provided that this is permitted by the state of health of the Insured; 5) hospitalisation caused by the need for the Insured to receive care from third parties in order to carry out the elementary acts of daily life, as well as long-term hospitalisation, determined by the physical conditions of the Insured that no longer allow recovery with medical treatment and that make it necessary to stay in a nursing home for care or maintenance physical therapy; 6) intoxications and injuries resulting from: • alcohol abuse; • use of hallucinogens; • non-therapeutic use of psychotropic drugs and narcotics; 7) voluntary non-therapeutic abortion; 8) the correction or elimination of malformations or physical defects, unless they result from a pathology or are the consequence of an accident, and without prejudice to the provisions under section C “Ancillary Benefits Area", letter K “Newborns"; 9) all procedures and interventions for the purpose of assisted reproduction, except for the provisions of the cover under section C “Ancillary Benefits Area", letter G “Assisted Reproductive Technology". In any case, the daily indemnity in lieu set out under section A "Hospitalisation", letter C “Italian National Health Service" is not recognised for this type of procedure; 10) injuries suffered as a result of the Insured's own criminal actions wilfully carried out or attempted, as well as deliberately carried out or permitted against his/her person; 11) clinical check-ups; 12) physical therapy services (where applicable) not provided by a medical specialist or by a professional with a degree in physical therapy or an equivalent qualification recognised in Italy, or provided in beauty or fitness centres; 13) the direct or indirect consequences of transmutation of the nucleus of the atom as well as of radiation caused by the artificial acceleration of atomic particles; 14) the consequences of war, insurrections, earthquakes and volcanic eruptions; 15) accidents resulting from the practice of air sports in general or any sport practised professionally; 16) accidents resulting from participation in races or competitions in cars that are not purely regularity races, or in motorbikes and motorboats, as well as related trials and training; 17) injuries sustained and illnesses occurring during the performance of military service or service in lieu thereof, voluntary enlistment, recall for mobilisation or for exceptional reasons; 18) expenses incurred as a result of the following mental illnesses: psychosis, neurotic personality disorders and other non-psychotic mental disorders, mental retardation and in any case all illnesses included in chapter 5 (MENTAL DISORDERS) of the 9th revision of the International Classification of Diseases (ICD9-CM) of the World Health Organisation and/or the taking of psychotropic drugs for therapeutic purposes; 19) services provided in convalescent and residential homes, health camps and nursing homes for dietary and aesthetic purposes or long-term care facilities, insofar as they are not considered “healthcare facilities", as well as gyms, gymnastic and sports clubs, beauty studios, health hotels, medical hotels, and wellness centres even if they have an annexed medical centre.

Are there any cover limits?

The Policyholder/Insured must notify the Company in writing of the existence and subsequent stipulation of other insurance policies for the same risk; in the event of a claim, the Policyholder or Insured must notify all the insurers, indicating to each the name of the others, pursuant to Article 1910 of the Italian Civil Code. The above is also valid in the event that the same risk is covered by contracts stipulated by the Insured with Entities, Funds, or Supplementary Health Funds. The right of recourse of the Company is reserved.
The following are the ceilings/sums insured, coinsurance and deductibles for the various options. Unless otherwise indicated, the ceilings are per Year/Family Unit and the coinsurance/deductibles are per event.

HOSPITALISATION	
Surgical/Non-surgical hospitalisation, surgical/non-surgical Same-Day hospitalisation, outpatient surgical procedure, Childbirth/therapeutic abortion, dental surgery, Major Surgery (MS), Transplantation, Post-surgical Rehabilitation, Major Morbid Events (MME)	full list of surgical procedures with ceiling (Int_PLAFONATI), MS and Dental Surgery (Int_ODONTOIATRICI)
Ceiling	€500,000
Conditions:	
In network	100% in case of C-section/therapeutic abortion, natural childbirth, dental surgery, myopia, reconstructive surgery. Deductible of €350 for hospitalisation without surgery, hospitalisation without surgery for post-op rehabilitation, hospitalisation without surgery for SIE and hospitalisation without surgery for long-term hospitalisation. Deductible of: €1,000 for hospitalisation with surgery; €250 fo surgical/non-surgical Same-Day Treatment; *€150 for Outpatie Surgical Procedure;* In case of MS €750 deductible per event. the event of surgery with surgery, no coinsurance and/or deductible.
Out-of-network, private service at public facility	100% in case of C-section/therapeutic abortion, natural childbirth. Coinsurance: 10%, min. €1,500 per event in case of same-da treatment with surgery, hospitalisation without surgery, hospitalisation without surgery for post-op rehabilitation, hospitalisation without surgery for Serious Health Events, hospitalisation without surgery for long-term hospitalisation. 10% coinsurance with minimum: €1,000 for non-surgical Sam Day Hospitalisation and myopia; 10% coinsurance, min. €1,75 for hospitalisation with surgery; €750 for Outpatient Surgical Procedure). 20% deductible minimum €1,000 in case of dental surgery an reconstructive surgery. in case of MS 15% coinsurance
Mixed scheme	For affiliated structures under direct scheme; for non-affiliate doctors/medical team and/or non-affiliated services under indirect scheme

Non-surgical hospitalisation	maximum limit of 5 days per hospitalisation and max. 3 hospitalizations per year exclusion if for diagnostic purposes and pre-op diagnosis
Non-surgical hospitalisation for Long-term Care	in cases of hospitalisation lasting over 30 days
C-section/therapeutic abortion (excluding Pre/Post-op)	In the case of C-section requested by the mother, and therefore not as a result of pathologies of the mother or of the unborn child that would make it necessary, the terms and conditions of natural childbirth apply.
Sub-ceiling:	€9,000
Expenses for newborn baby (sub-limit)	€1,000
Obstetric care (sub-limit)	€1,500
Conditions:	100%
Natural childbirth (excluding Pre/Post-op)	
Sub-ceiling:	€6,000
Expenses for newborn baby (sub-limit)	€1,000
Conditions:	100%
Dental surgery	Full list (Int_ODONTOIATRICI)
Sub-ceiling:	€10,000
Conditions:	
In network	100%
Out-of-network, private service at public facility	20% coinsurance, min. €1,000
Myopia	with a difference of more than 4 dioptres (as long as this is not caused by previous corrective surgery) or a visual impairment of one eye of 8 dioptres or more
Conditions:	
In network	100%
Out-of-network, private service at public facility	10% coinsurance, min. €1,000
Reconstructive surgery	mastectomy or quadrantectomy
Ceiling	€5,000
Pre/Post-op	90 days/90 days
Conditions:	
In network	100%
Out-of-network, private service at public facility	20% coinsurance, min. €1,000
Newborns Correction of Congenital Malformations	in the first year of life, increased to the first 10 years of life du to inability to perform surgery in the first year of life
Surgical procedures with ceiling	Full list (Int_PLAFONATI)
Conditions:	100% main procedure, 70% secondary procedures
Limit on hospital stay fee only Out-of-Network	€300 a day; €250 for surgical/non-surgical Same-Day Treatment; not provided for childbirth/therapeutic abortion; in

	case of hospitalisation for Long-term Care €200 per day for the first 6 months; reduced to €150 for the following months
Pre/Post-op	100 days/100 days
Post-op physical therapy/rehabilitation treatments	120 days, not provided for natural childbirth, myopia and dental surgery
Fee for accompanying person	€80 per day max 90 days – MS €180 per day max 90 days, not provided for Dental Surgery and Myopia
Nursing Care Limit for non-surgical hospitalisation	€50 a day max 5 days per event; increased to 30 days for post-op rehabilitation and MMEs
Nursing Care for non-surgical Same-Day Treatment, Outpatient Surgical Procedure, Childbirth/Therapeutic Abortion, Dental Surgery	NOT INCLUDED
Transport	€3,000, not provided for outpatient surgical procedure, dental surgery, myopia and National Health System
Indemnity in lieu	
Ceiling	300 days per person/year
Surgical/non-surgical hospitalisation	€100 a day
MS	€120 a day
Surgical/non-surgical Same-Day Treatment	€50 a day
Pre/Post-op	100 days/100 days, 100% (excluding hospitalisation for private service at public facility)
Post-op physical therapy/rehabilitation treatments	100%, 120 days, not provided for natural childbirth, myopia and dental surgery, 100% (excluding hospitalisation for private service at public facility)
SPECIALIST AND/OR OUTPATIENT OUT-OF-HOSPITAL CARE	
Highly Specialised (HS) Care and Diagnostics	Full list (ALTA_D)
Ceiling	€7,500
Conditions:	
In network	€33 deductible per invoice
In network not in direct form	45% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	60% coinsurance, min. €120 per invoice
Out-of-network	30% coinsurance, min. €60 per invoice
Co-pay	100%
Non-invasive prenatal genetic testing on foetal DNA	included in HS ceiling
Routine Diagnostics, Specialist Visits (SV), Physical Therapy and Acupuncture	excluding the examinations provided for in HS and dental and orthodontic examinations not due to accident; including specialist visits/dental and orthodontic examinations due to accident with ER certificate within 48 hours of the event if there are no Emergency Rooms in the place where the accident occurred, the Insured may submit a certificate issued by a substitute public medical facility and drawn up within 48 hours of the event.

Ceiling	€5,500
Conditions:	
In network	€33 deductible per invoice
In network not in direct form	45% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	60% coinsurance, min. €120 per invoice
Out-of-network	30% coinsurance, min. €60 per invoice
Co-pay	100%
Physical therapy	only for accident with ER certificate within 48 hours of the event; cerebral stroke; neoplasms; degenerative and homeoblastic neurological forms (multiple sclerosis, ALS, etc.); neuromyopathic forms: Mixed morbid forms affecting the neuromuscular system; cardiac surgery, thoracic surgery and limb amputation
Conditions:	
In network	€40 deductible per course of treatment
In network not in direct form	30% coinsurance, min. €90 per course of treatment
At TOP Clinics not in direct form	40% coinsurance, min. €120 per course of treatment
Out-of-network	20% coinsurance, min. €60 per course of treatment
Co-pay	100%
Physical therapy at home	
Conditions:	€20.00 per session
Acupuncture	
In-network/out-of-network conditions	20% coinsurance, min. €40 per invoice
Oncological care	services for oncological pathologies for home nursing care, chemotherapy, radiation therapy, other oncological therapies, specialist visits; when this ceiling runs out, those for HS and SV will be used
Ceiling	€12,000
Conditions:	100%
Speech therapy	for accident with an ER certificate within 48 hours of the event or for illness if carried out by a medical specialist or certified speech therapist
Ceiling	€1,000
Conditions:	
In network	€40 deductible per invoice
In network not in direct form	30% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	40% coinsurance, min. €120 per invoice

Out-of-network	20% coinsurance, min. €60 per invoice
Co-pay	100%
Specific learning disorders (SLD)	according to the provisions of DSM -5, provided that the diagnosis is certified by a physician specialised in child neuropsychiatry of the Italian National Health Service
Ceiling	€1,500.00 per family unit per year for moderate or severe cases or up to €500.00 per family unit per year for mild cases
Conditions:	
In network	€40 deductible per invoice
In network not in direct form	30% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	40% coinsurance, min. €120 per invoice
Out-of-network	20% coinsurance, min. €60 per invoice
Co-pay	100%
Psychotherapy	
Ceiling	€1,500
Conditions:	50% coinsurance
Orthopaedic implants or hearing aids	
Ceiling	€3,000
Conditions:	30% coinsurance, min. €50 per invoice
Dental care due to accidents	with ER certificate within 48 hours of the event
Ceiling	€7,000
Conditions:	100%
Additional services	paediatric visits (up to 14 years)
Ceiling	€1,500, sub-limit €500 per year/person
Conditions:	30% coinsurance
Eyewear	
Ceiling	€400; sub-limit €150 per year/person
Conditions:	100%
Comparative diagnosis	INCLUDED
Maternity package	visits and follow-up exams in the first six months of pregnancy; in case of miscarriage, within 3 months, 1 gynaecological and 3 psychological visits
Ceiling	€500
Conditions:	100%
ANCILLARY BENEFITS AREA	

Emergency Room Care	outpatient services following an accident without hospitalisation; the following benefits are also included with a prescription from the ER: plaster application and removal, diagnostic tests, medical care, medicines and transport
Ceiling	€1,000 per event per year
Treatment of drug addicts	for recovery from drug addiction in therapeutic communities affiliated with the Local Health Unit
Ceiling	€3,000 per person per year, maximum € 30,000 for all Insured
Conditions:	if the total claims of the Assisted parties exceed the amount of € 30,000, the contribution will be divided proportionally among the applicants
Advance on health costs	for MS, maximum 50% of the expense to be incurred within 50% of the Hospitalisation Area ceiling
Nursing care	for terminal illness with appropriate medical/hospital certification
Conditions:	€50 a day up to 90 days
Repatriation of body	in the event of the death of the Insured following admission (including same-day hospital) to a hospital abroad for illness or injury, with or without surgery
Ceiling	€2,000
Conditions:	excluding funeral ceremonies and burial expenses
Home hospitalisation	post-hospitalisation expenses for MS
Ceiling	€15,000, maximum 50 days per hospitalisation
Conditions:	
In network	100%
Out-of-network	10% coinsurance, min. €1,200 per event
Assisted reproductive technology	
Ceiling	€700 per family unit per year
Conditions:	expenses related to the Insured's travel/transfer and any accompanying person's costs if the treatment is carried out abroad are excluded
Post-delivery care	
Ceiling	Unlimited
Conditions:	full list (POST_P), within 1 year of childbirth
Spa treatments for minors	
Ceiling	Unlimited
Conditions:	max. 1 course of treatment per year, max. €35.00 per session
Down syndrome (child of Insured)	
Ceiling	€1,000 a year, max. 5 years
Conditions:	for diagnosis of Trisomy 21 in the first 3 years of life
Health Account	INCLUDED

Indemnity for parents in nursing home	for admissions to nursing home of at least 12 consecutive months
Ceiling	€350 per year/person
Conditions:	in the absence of medical reimbursements during the insurance year
PREVENTION AREA	
Follow-up visits	At affiliated facilities
Ceiling	Unlimited
Conditions:	100% - 1 visit per month per Insured
Flu vaccine	Out-of-network
Ceiling	Unlimited
Conditions:	1 vaccine a year per Insured
Herpes zoster prevention	At affiliated and non-affiliated facilities
Ceiling	Unlimited
Conditions:	age > 55 years, deductible €36.15 per service
Paediatric check-up	At affiliated facilities
Ceiling	Unlimited
Conditions:	deductible €36.15 per service – as per list, between 6 months and 6 years of age
Nutritional consult and personalised diet	1 consult and personalised diet every two years per person
Ceiling:	
In network	Unlimited
Out-of-network	€80.00 per person for two-year period (€50.00 for the visit and €30.00 for the diet)
Stem cell preservation	
Ceiling	€500 per family unit per year

What are my obligations? What are the company's obligations?

What to do in case of a claim?	**Reporting a claim:** the Insured or his/her assignees must report the claim to Intesa Sanpaolo RBM Salute as soon as they can, in writing or via web (reserved area/mobile app). A claim for compensation may be submitted in the same manner.
	Direct/affiliated care: the Insured may access the health and dental services of the Network made available by Intesa Sanpaolo RBM Salute after activating the Operations Centre.
	Processing by other companies: not included.
	Limitation: the right to pay the premium instalments shall lapse one year after the individual due dates (Article 2952 of the Italian Civil Code). Other rights deriving from the insurance contract lapse in two years from the day of the accident.

Incorrect or reticent statements	The Policyholder and Insured must make accurate and complete statements without reticence; if they fail to do so, they may forfeit all or part of their right to compensation and the insurance may cease (Articles 1892, 1893 and 1894 of the Italian Civil Code). The Insured must notify Intesa Sanpaolo RBM Salute of any worsening of or reduction in risk.
Company obligations	The Company shall: **a) Direct care scheme** - provide authorisation, to the complete request and for which the technical, medical and insurance investigation has had a positive outcome. To this end, therefore, the Insured must take action with adequate advance notice and in any case with at least 2 days (48 hours) notice with respect to the last date provided for the response from the Operations Centre. **b) Payment scheme** - make payment to the Insured within 10 working days of receipt of the request for payment complete with all the necessary medical and expense documentation.

When and how should I pay?

Premium	Although the premium is annual and indivisible, it must be paid in monthly instalments in advance as shown on the policy certificate. The insured amounts and premiums are not indexed. Premium includes tax. The premium is paid by the Policyholder to Intesa Sanpaolo RBM Salute by bank transfer.
Refund	There is no refund of the premium since, in the event of loss during the year of the requisites to benefit from the insurance cover, the cover is active until the first useful expiry date.

When does cover begin and when does it end?

Duration	The insurance contract has a duration of 2 years starting at 00:00 am on 01/01/2022, if the premium or the first instalment of premium has been paid; otherwise it shall take effect at midnight on the day following payment. Cover expires at midnight on 31/12/2023. There are no waiting periods (when cover is not active).
Suspension	If the Policyholder fails to pay the premiums or the following premium instalments, the insurance cover shall is suspended from midnight of the 15th day after the expiry date and shall resume effect from midnight of the day following payment. Subsequent deadlines must, however, be met (Article 1901 of the Italian Civil Code). Once the terms have expired, Intesa Sanpaolo RBM Salute may terminate the contract by registered letter and is still entitled to claim the expired premiums.

How can I cancel my policy?

Change of mind after underwriting	The Policyholder is not entitled to change of mind after signing.
Termination	In addition to the cases of termination provided for by law, the Policyholder may withdraw immediately and without charge - by registered letter with acknowledgement of receipt - in the case of events that demonstrate a situation, albeit preliminary, of financial instability for the Company, such as: (a) no or inadequate technical provisions; (b) no or inadequate solvency margin; (c) requests by IVASS requiring the Company to prepare a financial recovery plan to restore its solvency margin;

	(d) determination by IVASS of serious financial losses; (e) initiation of the Extraordinary Administration. In this case, the premium instalments not yet paid shall not be due to the Company. The Policyholder may also withdraw unilaterally at the end of the first year of cover in the event of manifest inadequacy of the standard of service rendered by the Company with respect to the level of service guaranteed, which is demonstrated by the application of the maximum penalty set out therein.

Who is this product for?

The insurance product is intended for personnel in service under an Italian contract with the UniCredit Group, provided that these personnel are enrolled in Uni.C.A., who intend to obtain reimbursement of health expenses incurred as a result of injury or illness.

What costs do I have to cover?

There are no additional fees charged to the policyholder.

HOW CAN I FILE COMPLAINTS AND RESOLVE DISPUTES?

To the insurance company	Complaints about the contract or an insurance service must be in writing and sent to the Intesa Sanpaolo RBM Salute S.p.A. Complaints Office either: - filling out the online form(https://www.intesasanpaolorbmsalute.com/reclami.html) - by ordinary or registered mail: Intesa Sanpaolo RBM Salute S.p.A. – Ufficio Reclami - Sede Legale - Via A. Lazzari no. 5, 30174 Venice – Mestre (VE) - by fax: 0110932609 - by email: reclami@intesasanpaolorbmsalute.com - by certified email: reclami@pec.intesasanpaolorbmsalute.com If you do not use the online form, you must indicate in your complaint to receive a clear and complete reply: - name, surname, address and date of birth of the Insured - name, surname, address of the person filing the claim, if other than the Insured (e.g., consumer association, lawyer, family member, etc.), with power of attorney signed by the Insured and a copy of the relevant ID document - case number - concise and complete statement of the facts and reasons for the complaint. Requests for clarification or information, claims for compensation for damages or fulfilment of contract, are not considered complaints. Intesa Sanpaolo RBM Salute shall reply to the complaint within 45 days of the date of its receipt.
To IVASS	In the event of an unsatisfactory outcome or late response, you can contact IVASS, Via del Quirinale, 21 - 00187 Rome, fax 06.42133206, certified e-mail: **ivass@pec.ivass.it**. More info at: **www.ivass.it**
BEFORE RESORTING TO A COURT OF LAW, alternative dispute resolution systems can be used, such as:	
Conciliation	With the necessary assistance of a lawyer, you can contact a Conciliation Body to be chosen from among those listed in the appropriate register kept by the Italian Ministry of Justice, available at **www.giustizia.it.** (Law no. 98 of 9/8/2013) in order to reach an agreement between the parties. An attempt at conciliation is a condition for proceeding with a civil case. A request for conciliation may be sent to:

	Intesa Sanpaolo RBM Salute S.p.A. Claims Department Via A. Lazzari no. 5, 30174 Venice – Mestre (VE) or by email: reclami@pec.intesasanpaolorbmsalute.com
Assisted negotiation	Through a request from your attorney to Intesa Sanpaolo RBM Salute. The assisted negotiation is optional and does not constitute a condition for admissibility of court proceedings.
Other existing alternative dispute resolution systems	For the resolution of cross-border disputes it is possible to submit a complaint to IVASS directly or to the competent foreign system by requesting the activation of the FIN-NET procedure or by the applicable regulations.

FOR THIS CONTRACT, THE COMPANY HAS AN INTERNET AREA RESERVED FOR THE POLICYHOLDER/INSURED (CALLED *INSURANCE HOME*), SO AFTER SIGNING YOU CAN CONSULT THIS AREA AND USE IT TO MANAGE THE CONTRACT ELECTRONICALLY.

INTESA SANPAOLO RBM SALUTE

Health Insurance for staff in service
of the **Unicredit S.p.A. Group**
Associated with
Uni.C.A. Cassa Assistenza

TERMS AND CONDITIONS

Please read the insurance conditions carefully before taking out the policy

FORM FI 2474

Version 01/2022

Intesa Sanpaolo RBM Salute S.p.A.

INTESA SANPAOLO
RBM SALUTE

TABLE OF CONTENTS

Condition of Insurance from page 1 to 55:

In accordance with Article 166 of the Insurance Code (Legislative Decree No. 209 of 7 September 2005) and the Guidelines issued by the ANIA [National Association of Insurance Companies] at the outcome of the "Simple and Clear Contracts" Technical Panel (6 February 2018), the forfeitures, nullities, limitations of guarantees and charges bearing on the Policyholder or Insured, contained in this contract, are shown in "underlined and bold" characters.

INTESA SANPAOLO
RBM SALUTE

To make the Terms and Conditions of Insurance clearer, these means were used:

Bold: words and concepts of particular importance
Grey background: forfeiture, nullity, limitation of cover, charges to be borne by the Policyholder or the Insured
Green box: examples

Section I

GLOSSARY

The Glossary is an integral and material part of the Terms and Conditions of Insurance. Unless otherwise stated, the terms and definitions listed below, which are marked with a capital letter, shall have the meaning given to each in this Glossary.

Terms stated in the singular include the plural, and vice versa. Terms denoting one gender include the other gender unless the context or interpretation indicates otherwise.

Insured: person who is covered by the insurance.

Insurance: the insurance contract.

Direct care: care at affiliated facilities/specialists included in the service agreement with Cassa Uni.C.A. with direct payment by the Company to the affiliated facilities/specialists of the amounts due for the care received by the Insured.

Nursing care: care provided by staff with a specific diploma.

Medical Record: a set of official documents valid as a public deed, drawn up during a hospital stay, whether same day or inpatient, containing the patient's full personal details, admission and discharge diagnoses, remote and recent clinical history, treatments carried out, surgical procedures performed, exams and clinical diary, discharge letter and the Hospital Discharge Summary (HDS).

Fund: Uni.C.A. Cassa Assistenza, Piazza Gae Aulenti n. 3, (Torre A), 20154 - Milan, TIN 97450030156; a welfare entity qualified[1] to receive contributions and to undertake the contracting of the health programme for tax and contribution purposes

[1] Article 51 "Determination of income from employment" of Italian Presidential Decree no. 917/1986.

TCIs: Terms and Conditions of Insurance.

Medical centre: A facility, even if not used as a hospital, not intended for the treatment of aesthetic problems, organised, equipped and duly authorised according to current legislation to provide diagnostic or therapeutic health services of particular complexity (diagnostic and instrumental examinations, laboratory analyses, use of electromedical equipment, physical therapy and rehabilitation treatments) and with hospital health management.

Company: Intesa Sanpaolo RBM Salute S.p.A.

Policyholder: Uni.C.A Cassa Assistenza, registered with the Italian Register of Health Funds.

Same-Day Hospitalisation: Stay in a healthcare facility that usually ends within a day following medical treatment or surgical procedures.

Surgical team: the team consisting of the surgeon, assistant surgeon, surgical assistant, the anaesthetist and any other person actively involved in the procedure.

Affiliated surgical team: Each surgical team - as defined above - falling under the service affiliated with Cassa Uni.C.A.

Deductible: Fixed amount to be borne by the Insured. Unless otherwise specified, it applies per event. For cover that provides for the payment of an indemnity for each day of hospital stay, it is the number of days for which the indemnity is not paid to the Insured.

Major Morbid Events: the events listed in Annex 3

Indemnity: the amount the Company owes the Insured in the event of a claim covered by these TCIs.

Accident: event due to a fortuitous, violent and external cause that produces objectively ascertainable bodily injuries. Therefore, in order for the event to qualify as an accident under the policy, three concomitant causes must occur:

- fortuitous means: the result of chance, accidental, unintentional, unforeseeable or unavoidable
- violent means: intense and capable of damage (thus excluding all slow degenerations, such as certain inflammations and fraying)
- "external" shall mean an "exogenous cause and not internal to one's own body (pre-existing pathological condition), or an event caused by an external force

Outpatient surgical procedure: surgical procedure performed without inpatient hospitalisation.

Long-term Care: Rehabilitation hospitalisation for recovery and/or improvement of the physical conditions of the Insured by means of medical and/or physical therapy treatments with stay in healthcare facilities dedicated to long-term care (e.g., assisted living facilities, ALFs), or units dedicated to long-term care, which therefore excludes long-term hospitalisation in which the physical conditions of the Insured are such that recovery cannot be achieved with medical treatment and the stay in a healthcare facility is made necessary by health care or physical therapy measures mainly for maintenance purposes.

Complex Outpatient Macroactivity (COM): Organisational mode of complex therapeutic and diagnostic services, by which different specialists interact in a coordinated manner. It allows for the provision of diagnostic, therapeutic and rehabilitative services that do not involve ordinary hospitalisation and that, due to their nature or complexity, require continuous medical and nursing care, which is not possible in an outpatient setting.

Illness: any alteration in health that is not due to an accident.

Oncological disease: Any disease determined by the presence of a benign or malignant neoplasm. This includes leukaemia, lymphomas, Hodgkin's disease, cancer in situ. It also includes tumours with direct invasion of neighbouring organs in the metastatic stage and relapses.

Family Unit: The entire family unit as defined in Art. 5 "Insurable categories" of the Terms and Conditions of Insurance (also TCIs).

Ceiling: maximum amount that can be paid by the Company in the event of surgery as shown in the Table "List of surgical procedures with ceiling".

Premium: The amount that the Policyholder owes the Company.

Hearing aid: external wearable electronic device, which amplifies or modifies the sound message to correct the quality and quantity of the hearing defect caused by illnesses for clinical stabilisation purposes.

Orthopaedic implants: artificial replacement of part of the body's limbs.
For example, orthoses (such as braces, corsets, knee pads, orthopaedic insoles) are excluded.

Mixed scheme: applies only to services in the Hospitalisation Area provided at facilities that are part of the Affiliated Network (accessible directly, after activation of the Operations Centre), but with a medical team and/or service that are not covered by the agreement (the relative expenses of which are reimbursable indirectly under the conditions and within the limits established by the TCIs).

Payment scheme: care provided at facilities/specialists that do not fall within the service agreement with Cassa Uni.C.A. or at facilities/specialists that do fall within the service agreed with Cassa Uni.C.A., but without the Insured having followed the procedures required for access to Network services. In this case, the payment of benefits shall be made by the Insured, and the Company shall pay the expenses under the conditions and within the limits established by the TCIs.

Hospitalisation: an in-patient stay involving overnight stay at a healthcare facility.

Coinsurance: the sum, expressed as a percentage, deducted from the expenses actually incurred and eligible for compensation under the terms of the contract, which shall be borne by the Insured.

Claim: the damaging event for which insurance cover is provided.

Healthcare facility: any nursing home, institute, or hospital in Italy or abroad, duly authorised in accordance with legal requirements and by the competent authorities, to provide hospital healthcare.

Affiliated Healthcare Facility: Each nursing home, institute, hospital - as defined above - that has an agreement with Cassa Uni.C.A. The list of Authorised Centres is available under "Strutture convenzionate" on the website www.unica.previmedical.it.

Physical Therapy and Rehabilitation Treatments: hysical and rehabilitation medicine treatments provided by a doctor or professional with a degree in physical therapy or an equivalent qualification recognised in Italy, at medical centres, aimed at enabling the recovery of the functions of one or more organs or systems affected by illness or accident eligible for compensation under the policy.

The definition - and therefore, the insurance cover - does not comprise services:

- aimed at the treatment of aesthetic problems
- treatments carried out with instruments whose pre-eminent use is in the field of aesthetic medicine.

Specialist Visit: health care service provided by a doctor with a specialisation, for diagnoses and prescriptions of therapies for which this specialisation is intended. Only traditional medicine visits are allowed as well as those carried out at the Insured's home in cases where the latter is unable to move.

Examinations by general practitioners are not considered specialist visits.

INTESA SANPAOLO RBM SALUTE

CHAPTER 1 – GENERAL RULES GOVERNING THE CONTRACT

Article 1. Information on Intesa Sanpaolo RBM Salute S.p.A.

Registered under number 1.00161 in the Register of Insurance Companies Authorised to carry out insurance business by ISVAP Order no. 2556 of 17/10/2007[2].

Website: www.intesasanpaolorbmsalute.com

Email: info@intesasanpaolorbmsalute.com

CERTIFIED E-MAIL: comunicazioni@pec.intesasanpaolorbmsalute.com

Article 2. Waiting period

Not included.

Article 3. Indexing of premiums and insured amounts

The premiums and insured amounts are not indexed.

Article 4. Limitation and forfeiture of rights under the contract

The right to pay the premium instalments shall lapse one year after the individual due dates[3].

Example: if the premium instalment is due 31 December 2022, Intesa Sanpaolo RBM Salute may require payment by 31 December 2023.

Other rights deriving from the insurance lapse in two years from the day of the accident.

Article 5. Insured categories

The Insurance is provided for UniCredit Group personnel in service at a location in Italy under Italian contracts, provided that they are members of Uni.C.A.

The Insurance shall also cover the following family members:

- free of charge, for the spouse and dependent children;
- with payment of the relevant premium for:

1) spouse who is not a dependent spouse or a cohabiting partner (living as man and wife) (the latter provided they are listed in the family status);

[2] OJ 255 of 2 November 2007

[3] Article 2952 "Limitation in matters of insurance" of the Italian Civil Code

2) children who are not dependent as shown in the family status of the other separated or divorced parent;
3) other family members listed in the family status, including children of the spouse/cohabiting partner living as man and wife only;
4) children who are not dependent and not cohabiting and who are under 35 years of age at the date of inclusion in the cover, not married and not cohabiting as man and wife (with a total income limit of €26,000 gross per annum).
5) non-cohabiting parents aged over 60 years (with a total gross income limit of €26,000 per annum).

In the cases 1), 2) and 3), inclusion must concern all the persons listed in the family status (except for persons who already benefit from other forms of healthcare provided by their employer for whom an exemption from the above obligation is requested).

If, in the event of assignment to a new place of work outside Italy, the insured employee in service moves to the new location without the entire family unit, the Insurance cover shall still be effective for the insured persons who have not moved.

The spouse, including if legally and effectively separated, may always be included in the cover, even if their domicile and/or residence is different from that of the employee in service.

If the insured join this insurance during the term of the contract - as long as this is expressly allowed by the Terms and Conditions of Insurance (e.g., marriage, new births, etc.) - the annual maximum amount provided for each family unit shall apply.

The Insurance is active:

- regardless of the physical condition of the Insured;

- without territorial limitations;

- until the end of the annum (31 December) in which the Insured turns 85 years of age, except for the provisions of Article 19 "Non-insurable persons".

Article 6. Declarations on circumstances concerning risk - Health Questionnaire

The Insured must make accurate and complete statements without reticence; failure to do so may result in the complete or partial forfeiture of the Indemnity and in the termination of the Insurance[4].

The Insured, his/her family members and assignees shall always allow the Company to verify, by means of investigations or checks, the truthfulness of all the declarations and data

[4] Articles 1892 "Incorrect statements and reticence with intent or gross negligence", 1893 "Incorrect statements and reticence without intent or gross negligence" and 1894 "Insurance in the name of or on behalf of third parties" of the Italian Civil Code.

acquired (e.g. family ties, dependents), which are necessary elements for evaluating the validity of the Insurance for them.

The Insured must notify the Company of any worsening of or reduction in risk.

The Health Questionnaire does not to be completed.

Article 7. Commencement of Insurance – Tacit Renewal – Right to withdraw

7.1 Effective date

The Insurance lasts for 2 years and is effective:

- from 0:00 am on 01/01/2022 if the premium or the first premium instalment has been paid
- otherwise it shall take effect at midnight on the day after payment.

It expires at midnight on 31/12/2023.

7.2 Tacit renewal

The contract does not provide for tacit renewal, therefore, at the expiry of the contract, the insurance shall be devoid of further effect".

7.3 Right to withdraw

The Policyholder's right to withdraw is provided.

Article 8. Underwriting of Cover – Change of the Insured

The insurance shall be afforded to the Insured with domicile in Italy, i.e., employees and their family members as identified in the definition of family unit that the Policyholder shall indicate by:

- 28 February 2022 for staff in service
- 30 April 2022 for long-term absent or outgoing staff

After this term has elapsed, no changes of the insured shall be possible, subject to the following exceptions.

8.1 Inclusion during the year

Inclusion after the above dates is only allowed in the following cases:

a) new hire;

b) return to Italy of UniCredit employees who had previously expatriated (ex Expat), starting from the day of return, or, if later, from the day following the end of coverage provided for expatriate personnel;

c) birth, adoption or custody of a child;

EXTRA

d) marriage;

e) start of cohabitation for the cohabiting partner living together as man and wife and/or family member;

f) exclusion of a family member from other healthcare cover taken out by the employer.

In such cases, the insurance cover shall be effective from 12:00 pm on the date of the event, as per personal data certification and provided that the Company is notified within 90 days of that date, by means of a written communication to be sent to the Company.

Inclusions in the first half of the year (commencing on the effective date of Insurance): 100% of the Annual Premium is due, for the entire period of cover.
Inclusions in the second half of the year (commencing on the effective date of Insurance): 60% of the Annual Premium is due, for the entire period of cover.

8.2 Termination of cover during the year

Termination of cover before its natural expiry date of 31/12/2023 is only possible upon the occurrence of the following events:

a) termination of the employee's employment;

b) death of the employee or of an insured family member;

c) divorce/separation by court ruling for the employee's spouse;

d) the termination of cohabitation by the cohabiting partner and/or the family member who is not a dependent for tax purposes; in the case of a child who is not a dependent for tax purposes, cover may only be terminated if one of these two conditions also applies:

- establishment by the child of his/her family unit (marriage/cohabitation as man and wife);
- earning by the child in the tax year in which s/he leaves the family unit of a total income of more than €26,000 gross per annum;

e) inclusion of a family member in healthcare cover taken out by the employer;

f) reaching of the age of 85, subject to the possibility of maintaining cover under the terms of Article 9.9 "Age Limit";

g) exclusion of the employee resolved on in accordance with the Articles of Association and the Regulations by the Board of Directors of the Policyholder.

h) in the event of the assignment of the employee in service to a new place of work abroad (the Insurance remains in any case active for the insured persons who have not moved, as governed under in Article 8.1 "Insurable Persons")

In the cases under a), c), d), e) and f), the insurance shall cease to be valid on the first annual expiry date following the occurrence of the event.

In the event of termination of the employee's employment relationship (with the exception of dismissals for just cause and subjective just reason or terminations with the establishment

EXTRA

of an employment relationship with a company outside of the UniCredit Group), the employee and any family members insured shall remain covered until the first annual expiry date following the event.

In the event of the death of an employee in service, any family members insured will remain covered until the first annual expiry date following the event.

In the event of exclusion of an employee by the Board of Directors of the Policyholder in accordance with the Articles of Association and the Regulations, the holder and any insured family members shall immediately cease to be covered upon the occurrence of the event.

In the event of termination of coverage for an employee in service due to assignment to a new place of work abroad, coverage will cease immediately upon the occurrence of the event.

In all of the above cases, no reimbursement of the premium shall be made.

8.3 Change of cover during the year

The following changes may occur during the term of cover.

a) management of fiscal burdens

the notification of the tax burden in each year of cover shall be made by the Insured based on the consolidated income situation of his/her family member in the previous year. Therefore, any changes in the income situation of the Insured's family members during the year shall not affect the premium for the current year, but shall only be the basis for determining the premium for the following year.

b) Assignment to an employee during the year of the title of Executive or for staff who are already Executives in the case of assignment to another Global Band Title and vice versa:

the insured remains covered by the insurance until the end of the year in which the change in job title occurred.

As of January 1st of the following year, for the Insured, the terms and conditions set forth in the "Insurance Plan" relating to the new job title/Global Band Title for Executives shall apply. The Insured, through the Policyholder, has the option of including the employee's family members in the insurance cover as per Article 9.1 "Insurable persons," items 1) to 5).

c) termination of employment due to retirement:

in case of retirement of the employee, the insurance cover is effective until the end of the year in which the employment relationship ceases.

d) change for an already insured family member in the cohabitation/non-cohabitation status resulting from the family status:

A change in the cohabitation status of an insured family member during an insurance year shall not affect the premium due for the year in which the change occurred.

EXTRA

e) change from cohabiting partner living as man and wife to spouse:

If an insured cohabiting partner living as man and wife marries during the course of an insurance year, the change shall not affect the premium due for the year in which the marriage took place.

Article 9. Territorial Validity

The insurance is valid worldwide.

Article 10. Policyholder's obligations to provide documents

The Policyholder shall give the Insured:
a) Terms and Conditions of Insurance
b) Privacy Policy in Annex 6 to this Contract
The aforesaid documents are the only for which the Company assumes obligations with reference to the services indicated therein. The drafting of any other documents (e.g., operating guides) shall be evaluated and, if necessary, carried out by the Company, which shall not recognise the validity of documents relating to this Insurance, drawn up by others.

Article 11. Tax regime

Tax on Premiums: 2.50%
Tax on Indemnities: not included.
Taxes related to the Insurance shall be borne by the Policyholder also in the case of advance payment by the Company.

Article 12. Complaints

Complaints concerning a Contract or insurance service are to be sent to the Company in the manner set forth at www.intesasanpaolorbmsalute.com/Reclami.

Article 13. Alternative dispute resolution systems: conciliation

For disputes related to this Contract (including disputes regarding its interpretation, validity, performance and termination) before proceeding through the courts, it is mandatory to submit the case to a Conciliation Body listed in the Register of the Italian Ministry of Justice and based in the place where the judicial authorities are territorially competent[5].
An attempt at conciliation is a condition for admissibility of court proceedings.
If the dispute is not settled by conciliation, the Company, Policyholder and Insured are free to resort to judicial authorities.

Article 14. Jurisdiction

For disputes related to this Contract (including disputes regarding its interpretation, validity, performance and termination):
- between the Company and the Policyholder: shall be settled by the judicial authority where the Policyholder has its registered office

[5] Legislative Decree 28/2010 on conciliation aimed at reconciling civil and commercial disputes, as amended.

- between the Company and the Insured: shall be referred to the judicial authorities at the place of residence (if in Italy) or domicile of the Insured or assignee.

The Company, Policyholder and Insured may always resort to conciliatory systems.

Article 15. "Home Insurance"

"EasyUnica" mobile app

The Insured may access "EasyUnica" to access the following features:

- display and modify personal and contact data
- display Operations Centre contacts
- search for affiliated Network facilities
- view the status and details of one's cases
- pre-activate direct care services.

The Insured already registered in the Reserved Area will use the same credentials (login and password) to access the services via the Mobile APP. Otherwise, the Insured must register for the Reserved Area. For all web functions (see specific documentation published on the websites www.unica.unicredit.it and www.unica.previmedical.it).

Article 16. Law applicable to the Contract – Reference to the provisions of the Law

The insurance shall be governed by Italian law. The provisions of the law shall apply for all matters not expressly governed by this contract.

It is understood that in the event that legislative changes occur that may require changes to the contractual terms and conditions, the Parties shall meet to define the new insurance terms and conditions.

EXTRA

INTESA SANPAOLO RBM SALUTE

Section II

CHAPTER 1 - INSURED SERVICES

Article 17. Description of the insured services

The Company guarantees the benefits indicated below, provided that they are the result of an accident, illness or childbirth, eligible for reimbursement under the terms of the contract for expenses incurred by the Insured, whether directly or indirectly (in an affiliated network or in application of the reimbursement system) who is a member of the EXTRA Collective Health Plan.

In order for this insurance coverage to be operative, it is necessary that each claim for compensation be accompanied by medical documentation indicating the diagnostic question/diagnosis and the pathology for which the specified service is requested. Indication of a symptom alone is not sufficient (e.g., low back pain, sciatica, neck pain, asthenia, etc.). Health services that are not justified by any diagnostic question/diagnosis or pathology are not eligible for compensation, nor are services for the purpose of prevention and/or control, with the exception of those that are the object of specific cover (Article 8.6 – Prevention Area).

A) HOSPITALISATION

The Company guarantees the direct payment or reimbursement of the benefits indicated below, up to a total sum of €500,000 per family unit per insurance year. Without prejudice to the application of any coinsurance or deductibles provided for the individual benefits.
Moreover, in the event of surgery listed in the specific Table "List of surgical procedures with ceiling", the Company shall pay the expenses incurred therein up to the amount indicated in the aforementioned Table, subject to the application of any coinsurance or deductible provided. In the case of surgery with ceiling (i.e., for which a specific maximum limit of indemnity is provided) carried out directly, there is no application of coinsurance and/or deductibles.
The sub-limits of reimbursement shown in the Table "List of surgical procedures with ceiling" refer solely to the expenses incurred during hospitalisation involving surgery. Any coinsurance or deductibles provided for individual benefits shall be applied only once to the total amount of the expenses incurred for hospitalisation with surgery, considering as such the expense incurred for hospitalisation, and any healthcare services received prior to and after the surgical procedure within the terms provided for by this Article "Hospitalisation".
In the event that hospitalisation involves more than one surgical procedure identifiable in the Table "List of surgical procedures with ceiling", the Company shall pay 100% indemnity up to the amount with ceiling for the main procedure (as defined by the surgeon) and 70%

up to the amount with ceiling for the secondary surgical procedures, without prejudice to the application of any coinsurance or deductible.

With reference to "procedures with ceiling" (Annex 1), in the event that the estimate of the facility chosen by the insured is higher than the limit of indemnity provided for by the present insurance cover, at least two alternative facilities with agreements with the insured, if available in the territory, which can provide the service with costs lower than the limit of indemnity, are to be identified.

A BENEFITS FOR HOSPITALISATION IN A HEALTHCARE FACILITY

1) In the event of **hospitalisation with surgery**, the following costs shall be paid:

1.1 medical team fees, operating room fees, surgical materials including endoprostheses, necessary for the recovery of the Insured's autonomy, relating to the period of hospitalisation with surgery;

1.2 medical and nursing care, specialist medical consultations, treatments, diagnostic tests, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, medicines, all carried out during the period of hospitalisation;

1.3 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to a maximum of €300 per day, for all other admissions made indirectly.

Unnecessary expenses are in any case excluded;

1.4 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to hospitalisation;

1.5 diagnostic tests, medicines, medical, surgical and nursing services, as well as services aimed at recovering health such as treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation;

1.6 care aimed at recovering health, such as physical therapy and rehabilitation, carried out within 120 days of the end of hospitalisation and made necessary by the event that led to the hospitalisation;

1.7 individual private nursing care;

1.8 in the case of transplantation, expenses incurred in connection with harvest from donor are included.

2) In the event of non-surgical hospitalisation (medical hospitalisation), expenses shall be paid, up to a maximum of 5 days' hospitalisation for a maximum of 3 hospitalisations per year/person, relating to:

2.1 medical and nursing care, specialist medical consultations, treatments, diagnostic tests, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, medicines, all carried out during the period of hospitalisation;

2.2 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to a maximum of €300 per day, for all other admissions made indirectly.

Unnecessary expenses are in any case excluded;

2.3 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to hospitalisation;

2.4 diagnostic tests, medicines, medical, surgical and nursing services, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation;

2.5 individual private nursing care, up to €50 per day for a maximum of 5 days per event, in the case of non-surgical hospitalisation.

3) In the event of same day hospitalisation with surgery, the following costs shall be paid:

3.1 team fees, operating room fees, surgical material including endoprostheses, necessary for the recovery of the insured's autonomy;

3.2 medical and nursing care, specialist medical consultations, treatments, diagnostic tests, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, medicines, all carried out during the period of hospitalisation;

3.3 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to a maximum of €250 per day, for all other admissions made indirectly.

Unnecessary expenses are in any case excluded;

3.4 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to hospitalisation;

3.5 diagnostic tests, medicines, medical, surgical and nursing services, as well as care aimed at recovering health such as treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation;

3.6 care aimed at recovering health, such as physical therapy and rehabilitation, carried out within 120 days of the end of hospitalisation and made necessary by the event that led to the hospitalisation;

3.7 individual private nursing care.

4) In the event of same day hospitalisation without surgery, the following costs shall be paid:

4.1 medical care, specialist medical consults, treatments, diagnostic tests, medicines, all during the period of hospitalisation;

4.2 hospitalisation fees

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to a maximum of €250 per day, for all other admissions made indirectly.

Unnecessary expenses are in any case excluded;

4.3 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to hospitalisation;

4.4 diagnostic tests, medicines, medical, surgical and nursing services, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation;

For the purposes of this insurance coverage, it is specified that the Complex Outpatient Macroactivity (COM) is equivalent to same day hospitalisation if the medical record or hospital discharge letter or an equivalent document is produced.

5) In the event of outpatient surgical procedure, the following costs shall be paid:

5.1 team fees, operating room fees (if any), surgical material;

5.2 medical and nursing care, specialist medical consultations, treatments, diagnostic tests, care aimed at recovering health such as physical therapy and rehabilitation treatments, medicines, all carried out during the procedure;

5.3 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to the procedure;

5.4 diagnostic tests, medicines, medical, surgical and nursing services, care aimed at recovering health such as treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of the procedure and made necessary by the event that caused the procedure;

5.5 care aimed at recovering health, such as physical therapy and rehabilitation, carried out within 120 days of the end of the procedure and made necessary by the event that caused the procedure;

EXTRA

6) In the event of C-section/therapeutic abortion, the following expenses shall be paid:

6.1 team fees, delivery room fees, procedure material;

6.2 medical and nursing care, specialist medical consults, treatments, diagnostic tests, medicines, all during the period of hospitalisation;

6.3 hospitalisation fees without any daily limit. However, these do not include unnecessary expenses;

6.4 hospitalisation fees (crèche), diagnostic tests, medical and nursing care provided during hospitalisation (all related to the newborn child). Benefits shall be paid up to a sub-limit of €1,000.00 per year per family unit;

6.5 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to hospitalisation;

6.6 diagnostic tests, medicines, medical, surgical and nursing services, as well as care aimed at recovering health such as treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation;

6.7 care aimed at recovering health, such as physical therapy and rehabilitation, carried out within 120 days of the end of hospitalisation and made necessary by the event that led to the hospitalisation;

6.8 obstetrical care (during the period of hospitalisation and in the days preceding and following it). Benefits shall be paid up to a sub-limit of €1,500.00 per year per family unit;

The expenses referred to in items 6.1, 6.2, 6.3 and 6.4 shall be paid up to a maximum of €9.000 per family unit per year.

In the case of C-section requested by the mother, and therefore not as a result of pathologies of the mother or of the unborn child that would make it necessary, the terms and conditions of natural childbirth apply.

7) In the event of physiological childbirth, the expenses relating to the following shall be paid:

7.1 team fees, delivery room fees;

7.2 medical, nursing and obstetric care, specialist medical consults, treatment, diagnostic tests, medicines, all during the period of hospitalisation;

7.3 hospitalisation fees without any daily limit. However, these do not include unnecessary expenses;

7.4 hospitalisation fees (crèche), diagnostic tests, medical and nursing care provided during hospitalisation (all related to the newborn child). Benefits shall be paid up to a sub-limit of €1,000.00 per year per family unit;

7.5 diagnostic tests and fees for specialist and obstetric visits carried out in the 100 days preceding hospitalisation;

7.6 diagnostic tests, medicines, medical, surgical, nursing and obstetric services, treatments, carried out in the 100 days following the end of hospitalisation and made necessary by the birth.

The expenses referred to in items 7.1, 7.2, 7.3 and 7.4 shall be paid up to a maximum of €6,000 per family unit per year.

8) In the event of dental surgery (osteitis of the jaw, bone neoplasms of the upper or lower jaw, follicular or root cysts, adamantinoma and odontoma), the following expenses shall be paid:

8.1 specialist medical fees, dental implantology, treatment, diagnostic tests, medications, all related to the procedure;

8.2 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to the procedure;

8.3 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to €300 per day for all other indirect admissions (the amount is reduced to €250 per day for Same-Day admissions. However, these do not include unnecessary expenses.

8.4 Diagnostic tests, medicines, medical, surgical and nursing services, treatments, carried out in the 100 days following the procedure and made necessary by the procedure itself.

The expenses referred to in items 8.1, 8.2, 8.3 and 8.4 shall be paid up to a maximum of €10,000 per family unit per year.

The medical documentation required to obtain reimbursement of the expenses incurred consists of:

- X-rays and radiological reports for maxillary osteitis, follicular cysts, root cysts, adamantinoma, odontoma;
- medical reports showing bone neoplasms of the upper and/or lower jaw.

9) In the case of myopia with a difference between the eyes of more than 4 dioptres (as long as this is not caused by previous corrective surgery) or a visual impairment of one eye of 8 dioptres or more, the following expenses shall be paid:

9.1 refractive surgery and treatment with excimer laser, team fees, operating room fees, surgical material;

9.2 medical and nursing care, specialist medical consults, treatments, diagnostic tests, medicines, all during the period of hospitalisation;

9.3 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to €300 per day for all other indirect admissions (the amount is reduced to €250 per day for Same-Day admissions;

However, these do not include unnecessary expenses;

9.4 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to the procedure;

9.5 Diagnostic tests, medicines, medical, surgical and nursing services carried out in the 100 days following the procedure and made necessary by the procedure itself.

10) In the event of surgery for reconstructive purposes following mastectomy or quadrantectomy for the related contralateral adjustment, including psychological support, the following expenses shall be paid:

10.1 team fees, operating room fees, surgical material including endoprostheses, necessary for the recovery of the insured's autonomy;

10.2 medical and nursing care, specialist medical consultations, treatments, diagnostic tests, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, medicines, all carried out during the period of hospitalisation;

10.3 hospitalisation fees without any daily limit. However, these do not include unnecessary expenses;

10.4 diagnostic tests and medical fees for specialist visits carried out in the 90 days prior to hospitalisation;

10.5 diagnostic tests, medicines, medical, surgical and nursing services, as well as care aimed at recovering health such as treatments, including spa treatments (excluding hotel expenses), carried out in the 90 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation.

The expenses referred to in items 10.1, 10.2, 10.3, 10.4 and 10.5 shall be paid up to a maximum of €5,000 per family unit per year.

11) In the event of hospitalisation without surgery for post-surgical rehabilitation, the following expenses shall be paid:

11.1 medical and nursing care, specialist medical consultations, treatments, diagnostic tests, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, medicines, all carried out during the period of hospitalisation;

11.2 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to a maximum of €300 per day, for all other admissions made indirectly.

Unnecessary expenses are in any case excluded;

11.3 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to hospitalisation;

11.4 diagnostic tests, medicines, medical, surgical and nursing services, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation;

11.5 individual private nursing care, up to €50 per day for a maximum of 30 days per event, in the case of non-surgical hospitalisation.

12) In the event of hospitalisation without surgery due to Serious Health Events listed in Annex no. 3, expenses relating to the following shall be paid:

12.1 medical and nursing care, specialist medical consultations, treatments, diagnostic tests, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, medicines, all carried out during the period of hospitalisation;

12.2 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to a maximum of €300 per day, for all other admissions made indirectly.

Unnecessary expenses are in any case excluded;

12.3 diagnostic tests and medical fees for specialist visits carried out in the 100 days prior to hospitalisation;

12.4 diagnostic tests, medicines, medical, surgical and nursing services, as well as care aimed at recovering health such as physical therapy and rehabilitation treatments, including spa treatments (excluding hotel expenses), carried out in the 100 days following the end of hospitalisation and made necessary by the event that caused the hospitalisation;

12.5 individual private nursing care, up to €50 per day for a maximum of 30 days per event, in the case of non-surgical hospitalisation.

13) In the case of non-surgical hospitalisation for Long-term Care, if:

- there was a hospitalisation with surgery and post-surgical rehabilitation as part of the same hospitalisation and the total stay lasted more than 30 days;

- there was a hospitalisation with surgery and further hospitalisation in another medical institution specialising in post-surgical rehabilitation and the overall stay lasted more than 30 days;

the following expenses shall be paid at dedicated healthcare facilities:

13.1 Doctor's fees, treatment, diagnostic tests, as well as care aimed at recovering health such as physical therapy and rehabilitation, medicines, all carried out during the period of hospitalisation;

13.2 hospitalisation fees:

- without any daily limitation for direct admissions (in which case both the healthcare facility and the medical team must be affiliated);

- up to €200 per day for the first 6 months and €150.00 for the following months of stay, for all other admissions made indirectly. This provision is applicable starting from the 31st day of overall hospitalisation; up to the 30th day of overall hospitalisation, the provisions relating to hospitalisation fees for non-surgical hospitalisation for post-surgical rehabilitation shall apply.

Unnecessary expenses are in any case excluded.

If rehabilitation is carried out in healthcare facilities that are not dedicated to long-term care, from the 31st day of the overall hospitalisation, inpatient fees of up to €100 per day shall be paid for both direct and indirect inpatient stays.

In cases where there are no dedicated long-term care facilities:

- within 50 km from the residence/domicile of the Insured;
- or, if the hospitalisation with surgery and post-surgical rehabilitation took place in another city with respect to the city of residence/domicile and the Insured decides to continue the hospitalisation in the same city, within 50 km from the location of the healthcare facility where the hospitalisation took place,

the provisions set out in 13.2 Hospitalisation fees for non-surgical long-term care will apply.

The Company also covers expenses for the following plastic surgery procedures, occurring during the policy term, in the following cases:

1) Reconstructive surgery, including cosmetic surgery, for children under the age of three;

2) Reconstructive surgery following an accident eligible for compensation under the policy;

3) Reconstructive surgery following demolitive procedures or cancer surgery (limited to the anatomical site of injury) eligible for compensation under the policy.

4) Contralateral adjustment procedures related to reconstructive surgery following mastectomy or quadrantectomy

Expenses for the procedures in items 1), 2) and 3) shall be compensated pursuant to letter A, item 1.

Expenses for the procedures in item 4) shall be compensated pursuant to letter A, item 10.

B COINSURANCE

Payment of the expenses referred to in letter A above shall be made as follows.

Direct admissions

The expenses relating to the care received during hospitalisation shall be paid by the Company directly to the affiliated healthcare facility, without the application of any deductible or coinsurance to be borne by the Insured for the benefits referred to in letter A, items 6) to 10).

No coinsurance will be applied for pre- and post-hospitalisation healthcare, where applicable, even if not provided indirectly.

letter A, item 1): application of a deductible of €1,000 per hospitalisation;

letter A, items 2), 11), 12), and 13): application of a deductible of €350 per hospitalisation

letter A, items 3) and 4): application of a deductible of €250 per hospitalisation;

letter A, item 5): application of a deductible of €150 per event;

In the case of surgery included in the "Major surgery list": deductible of €750 per hospitalisation.

Indirect Admissions

Settlement will take place as follows:

letter A, item 1): application of 10% coinsurance with a minimum of €1,750 per hospitalisation;

letter A, items 2), 3), 11), 12) and 13): application of 10% coinsurance with a minimum of €1,500 per hospitalisation;

letter A, items 4) and 9): application of 10% coinsurance with a minimum of €1,000 per hospitalisation;

letter A, item 5): application of 10% coinsurance with a minimum of €750 per procedure;

letter A, items 6) and 7): no coinsurance is applied;

letter A, items 8) and 10): application of 20% coinsurance with a minimum of €1.000 per procedure;

In the case of surgery included in the "Major surgery list": 15% coinsurance.

Mixed-form admissions

The mixed scheme is accessible under the following circumstances:

- affiliated healthcare facility and service provided by non-affiliated doctors/medical teams
- affiliated healthcare facility and service not covered by agreement

In this case, the following apply:

- the terms and conditions set out for direct form, with reference to the costs of the affiliated healthcare facility;
- the terms and conditions set out for indirect form, with reference to the services provided by non-affiliated doctors/non-affiliated medical team and/or to services not covered by the agreement.

Examples:

Direct care service in case of hospitalisation with surgery
Ceiling €500,000.00
Cost of procedure €7,000.00
Deductible €1,000.00
Authorised benefit €7,000.00, of which €6,000.00 borne by the Company and €1,000.00 by the Insured

Mixed scheme in case of hospitalisation with surgery (affiliated facility and services provided by non-affiliated doctors)
Ceiling €500,000.00
Cost of procedure €20,000.00
Cost of facility €8,000.00
Deductible €1,000.00
Authorised benefit €8,000.00, of which €7,000.00 borne by the Company and €1,000.00 by the Insured
Cost of non-affiliated doctors €12,000.00
10% coinsurance with minimum €1,750.00
Indemnity €10,250.00 (€12,000.00 - €1,750.00, because the 10% coinsurance is less than the minimum not eligible for compensation)
Therefore, the Company covers a total of €17,250.00 for an overall claim of €20,000.00. The amount to be borne by the Insured is €2,750.00.

For this insurance cover to be operative, it is specified that services carried out in the 100 days prior to hospitalisation that have already been compensated within the scope of the Outpatient Specialist and/or Outpatient Services Area cannot be reconsidered for settlement under Hospitalization.

C ITALIAN NATIONAL HEALTH SERVICE

With reference to hospitalisation only, if the benefits governed by letter A above (with the exception of those referred to in item 5) are fully paid for by the Italian National Health Service, an indemnity in lieu shall be paid for each day of hospitalisation (including overnight stays) equal to:

- €100 a day for surgical or non-surgical hospitalisation;
- €120 a day in case of Major Surgery;

In the case of Same-Day treatment, which is completed during the day, an indemnity in lieu shall be paid in the amount of:

€50 a day for surgical or non-surgical hospitalisation.

The daily indemnities of this paragraph shall be paid up to a maximum of 300 days per person per year and shall not be granted for the benefits governed under Article 9.5 "Ancillary Benefits Area" under letter G below.

The first and last days are considered as one day.

The indemnity in lieu does not apply for a stay in the emergency/fast-track accident unit if it is not followed by admission to the same healthcare facility

In any case, the Company shall pay the services received prior to and following hospitalisation - eligible for compensation under the terms of the contract - in accordance with the provisions of letter A above, without the application of any coinsurance or deductible.

If hospitalisation takes place as private service in a public facility, the costs incurred shall be paid as per letter A, with the application of the coinsurance referred to in the items relating to indirect hospitalisation.

D ACCOMPANYING PERSON

With reference to the benefits referred to in letter A, points 1), 2), 3), 4), 5) 6), 7), 10), 11) and 12), expenses relating to board and lodging in a healthcare facility or hotel and transport costs for a person accompanying the Insured shall also be paid, with a daily limit of €80 and with a maximum of 90 days per family unit per year. In the event of Major Surgery (Annex 2) this daily limit is increased to €180 and a maximum of 90 days per family unit per year.
This cover does not apply to hospitalisation carried out at the total expense of the Italian National Health Service governed under letter C above.

E MEDICAL TRANSPORT

The expenses of transporting the Insured to and from the medical institution where s/he needs to go for hospitalisation under this policy and from one healthcare facility to another by medical transport if in Italy and by any means of transport, including non-medical, if the Insured is abroad, shall be paid. In the latter case, if the Insured uses his/her own car, the expenses incurred for tolls and fuel shall be paid against presentation of the relative receipts.
Reimbursement of expenses incurred in this capacity is limited to €3,000 per family unit per year. This benefit is paid only in the cases covered under letters A (excluding items 5, 8, and 9) and C above.

B) SPECIALIST AND/OR OUTPATIENT OUT-OF-HOSPITAL CARE

A.1 HIGHLY SPECIALISED CARE AND DIAGNOSTICS

The Company shall pay, up to a maximum of €7,500 per family unit per year, the "highly specialised" care services listed below.

Highly Specialised Diagnostics

- Amniocentesis after 35 years of age or if prescribed following suspected foetal malformation
- Digital angiography
- Arthrography
- Bronchography
- Cisternography
- Cystography
- Cholangiography
- Percutaneous cholangiography
- Cholecystography
- Coronarography
- Dacryocystography
- Fistulagram
- Phlebography
- Fluorescent angiography
- Galactography
- Hysterosalpingography
- Lymphography
- Myelography
- Pneumoencephalography
- Retinography
- Magnetic resonance imaging with or without contrast medium
- Sialography
- Scintigraphy

EXTRA

- Computed Axial Tomography (CT) with or without contrast medium
- Urography
- Vesiculodeferentography

Oncology-related therapies
- Chemotherapy
- Cobalt therapy
- Radiation therapy

Therapies
- Alcoholisation
- Dialysis
- Laser therapy (except for surgical and rehabilitation purposes; for the latter, however, this includes therapy for acute conditions up to a maximum of 18 sessions)

For this insurance cover to be operative, when laser therapy is carried out to eliminate or reduce persisting postoperative pain following a fracture, this is an "acute" pathological condition, and therefore eligible for compensation under the policy.

Endoscopic examinations
- Bronchoscopy
- Colonoscopy
- Duodenoscopy
- Oesophagoscopy
- Gastroscopy
- Proctoscopy

This cover also applies if the endoscopic examination requires a biopsy to be taken at the same time as the analysis.

Endoscopic surgery shall only be paid within the scope and terms of 'outpatient surgery'.

A.2 NON-INVASIVE PRENATAL GENETIC TESTING ON FOETAL DNA

The Company shall pay, within the limit per family unit per year as per letter A.1, expenses incurred for non-invasive prenatal genetic tests which, by analysing cell-free foetal DNA isolated from a sample of maternal blood, assess the presence of common foetal aneuploidies in pregnancy, such as those relating to chromosomes 21, 18, and 13 and sex chromosomes X and Y (e.g., Harmony test, Prenatal Safe, etc.). This cover will be recognised if carried out by the Insured from the age of 30 or if prescribed following an existing or suspected pathology.

In the absence of an existing or suspected pathology, the indication "search for chromosomal alterations" is still accepted, if supported by objective evidence of potential risk.

EXTRA

B ROUTINE DIAGNOSTICS AND SPECIALIST VISITS, PHYSICAL THERAPY AND ACUPUNCTURE

The Company shall also pay up to €5,500 per family unit per year:

1. analyses and diagnostic examinations, with the exception of those listed in letters A.1 and A.2 of "Specialist and/or outpatient out-of-hospital care area" and dental and orthodontic examinations not made necessary by an accident. In the latter case, the aforesaid examinations shall be paid as long as they are the result of an accident, documented by an Emergency Room certificate drawn up within 48 hours of the event, and the accident occurred within 24 months prior to the examination;
2. medical fees for specialist visits, with the exception of paediatric check-ups and dental and orthodontic examinations not made necessary by an accident. In the latter case, these visits shall be paid provided that they are the result of an accident, documented by an emergency room certificate issued within 48 hours of the event, and that the accident occurred within 24 months prior to the visit.

   For this insurance cover to be operative, when an outpatient surgical procedure is immediately preceded by a visit carried out by the same professional performing the procedure, aimed at verifying the conditions of the insured and the existence of the conditions to proceed with the procedure, this is part of the outpatient procedure itself and cannot be settled independently.

   For reimbursement of the aforementioned specialist visits, this care must be delivered by a doctor specialising in the claimed pathology.

   In addition, the medical acts (e.g., infiltrations) provide for the payment of the doctor's services only and not also of the drug, the cost of which shall be borne by the Insured.

   Specialist visits (also more than one) and diagnostic tests carried out to ascertain the pathological condition of the Insured (mental/psychiatric illness) and supported by a medical prescription containing the diagnostic question and/or diagnosis are also eligible for compensation. However, the Company reserves the right to request additional medical documentation or the report drawn up by a specialist.

   These services are also paid in all the cases in which the doctor goes to the domicile of the Insured in cases in which the latter is unable to move (a condition that must be certified by the attending doctor or by the medical facility that treated him/her), and in the case of specialist visits in paediatric age (up to 14 years of age of the child).

3. expenses for physical therapy solely at medical centres provided by a medical specialist or by a professional with a degree in physical therapy or an equivalent qualification recognised in Italy, accompanied by a prescription from a medical specialist indicating the rehabilitation treatment plan following:
   - Accident, documented by an emergency room certificate drawn up within 48 hours of the event and occurring within 24 months prior to physical therapy;
   - cerebral stroke;
   - neoplasms;

- degenerative and homeoblastic neurological forms; for example: multiple sclerosis, amyotrophic lateral sclerosis (ALS) and all chronic neurological forms due to degenerative processes affecting the central nervous system;
- neuromyopathic forms: Mixed morbid forms affecting the neuromuscular system;
- cardiac surgery, thoracic surgery and limb amputation.

Only in cases where there is a documented inability to go to a medical centre, invoices issued by the professional who delivered the care (who has a degree in physical therapy or an equivalent qualification recognised in Italy) may be recognised, accompanied by a prescription from a medical specialist indicating the rehabilitation treatment plan.

For this insurance cover to be operative, the physical therapy services prescribed following hospitalisation and necessary to recover health are provided in the manner and within the limits described in items A "Services related to hospitalisation in a medical institution" and B "Coinsurance". In such circumstances, therefore, the Insured cannot benefit from the present cover, which operates instead in cases in which physical therapy is directly prescribed as a therapy to be carried out following one of the events indicated above.

3.1 With reference to the aforementioned cases and subject to medical prescription, as an alternative to the provision of services at a Healthcare Facility that has an agreement with the Insured, the Insured may request, through the Operations Centre, to receive the services directly at home. The benefits shall be paid applying a deductible of €20 per access.

For this insurance cover to be operative:

• physical therapy services provided by a medical specialist (e.g., physiokinesitherapy) are eligible for compensation even if these are not provided at medical centres;

• physical therapy services provided by a physical therapist are eligible for compensation only if performed at medical centres with medical director (i.e., directed by a physician).

Therapies carried out in fitness or beauty centres are in any case excluded from cover.

4. expenses incurred for acupuncture prescribed by a Local Health Unit doctor or a medical specialist and performed by a doctor.

Coinsurance and Deductibles

The benefits referred to in items **A.1, A.2 and B (items 1 and 2)** above shall be paid against medical or specialist's prescription with the application of:

- a deductible of €33 per invoice (also including more than one service and provided that it relates to the same diagnostic question or pathology) if performed in affiliated healthcare facilities;

- 30% coinsurance with a minimum of €60 per invoice (also including more than one service incurred and relating to the same diagnostic question or pathology) if not performed in affiliated healthcare facilities;
- 45% coinsurance with a minimum of €90 per invoice (also including more than one service incurred and relating to the same diagnostic question or pathology) if performed in affiliated healthcare facilities without resorting to direct form;
- 60% coinsurance with a minimum of €120 per invoice (also including more than one service incurred and relating to the same diagnostic question or pathology) if performed in affiliated healthcare facilities indicated in the "TOP Clinics List" without resorting to direct form.

Benefits under **letter B (item 3)** shall be paid based on a specialist's prescription applying:

- a deductible of €40 per course of treatment if carried out in affiliated healthcare facilities;
- 20% coinsurance, with a minimum of €60 per course of treatment, if not carried out in affiliated healthcare facilities;
- 30% coinsurance with a minimum of €90 per course of treatment, if carried out in affiliated healthcare facilities without resorting to direct form;
- 40% coinsurance with a minimum of €120 per course of treatment, if carried out in affiliated healthcare facilities in the "TOP Clinics List" without resorting to direct form.

In order for a single coinsurance or deductible to be applied, the claim must be submitted by the Insured at the end of the course of treatment.

Services referred to in **letter B (item 3.1)** shall be paid subject to a deductible of €20 per access.

The benefits under **letter B (item 4)** shall be paid with a 20% coinsurance, minimum €40 per invoice, both direct care and with reimbursement.

Examples for letter A.1.

Direct care scheme
Ceiling €5,500.00
Cost of knee MRI €245.00
Deductible €33.00
Authorised benefit €245.00, of which €212.00 borne by the Company and €33.00 by the Insured

Reimbursement scheme in TOP Clinics without direct care
Ceiling €5,500.00
Claim for knee MRI €245.00
60% coinsurance minimum €120.00

Indemnity €98.00 (€245.00 - €147.00, because the 20% coinsurance is higher than the minimum not eligible for compensation)

Examples for letter B, item 3

Direct care scheme
Ceiling €5,500.00
Cost of massage therapy (3 sessions) €240.00
€40.00 deductible per course of treatment
Authorised benefit €240.00, of which €200.00 borne by the Company and €40.00 by the Insured

Payment scheme
Ceiling €5,500.00
Cost of massage therapy (3 sessions) €240.00
20% coinsurance minimum €60.00 per course of treatment
Indemnity €180.00 (€240.00 - €60.00, because the 20% coinsurance is less than the minimum not eligible for compensation)

Examples for letter B, item 3.1
Ceiling €5,500.00
Cost of massage therapy (3 sessions) €240.00
Deductible €20.00 per session
Authorised benefit €240.00, of which €180.00 borne by the Company and €60.00 by the Insured

C ONCOLOGICAL CARE

The Company shall pay, up to a maximum of €12,000 per family unit per year, oncology-related services incurred for:

- home nursing care;
- chemotherapy;
- radiation therapy;
- other cancer treatment therapies;
- specialist visits.

For the payment of the indemnity of the aforementioned specialist therapies and visits, this care must be delivered by a doctor specialising in the claimed pathology.

Should the aforementioned benefits are also covered by the previous letters A and B of "Specialist and/or outpatient out-of-hospital care area", in the event of payment of the

benefits, the ceiling provided for "Oncological Care" shall be paid first. When this ceiling is exhausted, the ceiling for letters A and B above will be used.

This cover does not apply if oncological care is delivered on an in-patient basis, including same-day treatment.

For this insurance cover to be operative, the specialist visits for oncological follow-up are paid under this cover for a maximum period of 10 years from the date of onset of the pathology.

D SPEECH THERAPY

The Company shall pay, up to a maximum of €1,000 per family unit per year, expenses incurred for speech therapy following an accident (documented by an Emergency Room certificate drawn up within 48 hours of the event and occurring within 24 months prior to speech therapy) or illness, provided that it is provided by a medical specialist or certified speech therapist.

The benefits listed above shall be paid on medical or specialist prescription and applying:

- a deductible of €40 per invoice if carried out in affiliated healthcare facilities;
- a 20% coinsurance with a minimum of €60 per invoice, if carried out in non-affiliated healthcare facilities;
- a 30% coinsurance with a minimum of €90 per invoice, if carried out in affiliated healthcare facilities without resorting to direct form;
- a 40% coinsurance with a minimum of €120 per invoice, if carried out in affiliated healthcare facilities in the "TOP Clinics List" without resorting to direct form.

Examples for letter D

Direct care scheme
Ceiling €1,000.00
Cost of speech therapy (10 sessions) €400.00
Deductible €40.00
Authorised benefit €400.00, of which €360.00 borne by the Company and €40.00 by the Insured

Reimbursement scheme in TOP Clinics without direct care
Ceiling €1,000.00
Claim for 10 sessions: €400.00
40% coinsurance minimum €120.00
Indemnity €240.00 (€400.00 - 40%)

E SPECIFIC LEARNING DISORDERS (SLD)

The Company covers, up to a maximum of €1,500 per family unit per year for cases defined as moderate or severe, according to DSM-5, or up to a maximum of €500 per family unit per year for cases defined as mild, according to DSM-5, the expenses incurred for the treatment and care of specific learning disorders (SLD), according to the provisions of DSM-5, provided that:

- ✓ the diagnosis is certified by a physician specialised in child neuropsychiatry of the Italian National Health Service;
- ✓ the service is prescribed by a specialist or primary care physician.

The Company pays these expenses applying:

- a deductible of €40 per invoice if carried out in affiliated healthcare facilities;
- a 20% coinsurance with a minimum of €60 per invoice, if carried out in non-affiliated healthcare facilities;
- a 30% coinsurance with a minimum of €90 per invoice, if carried out in affiliated healthcare facilities without resorting to direct form;
- a 40% coinsurance with a minimum of €120 per invoice, if carried out in affiliated healthcare facilities in the "TOP Clinics List" without resorting to direct form.

Examples for letter E

Direct care scheme
Ceiling for moderate or severe cases €1,500.00
Cost of care €130.00
€40.00 deductible per invoice
Authorised benefit €130.00, of which €90.00 borne by the Company and €40.00 by the Insured

Payment scheme
Ceiling for minor cases €500.00
Cost of care: €80.00
20% coinsurance minimum €60.00 per invoice
Indemnity €240.00 (€80.00 - €60.00, because the 20% coinsurance is less than the minimum not eligible for compensation)

F PSYCHOTHERAPY

The Company shall pay, up to a maximum of €1,500 per year per family unit, expenses incurred for psychotherapy prescribed by a Local Health Unit doctor or specialist, applying 50% coinsurance of the cost incurred and documented, whether in-network or out-of-network.

Under the present cover and relative ceiling, specialist visits are also compensated in addition to the initial assessment of the pathology.

Examples for letter N

Direct care or payment scheme
Ceiling €1,500.00
Cost of psychotherapy: €200.00
50% coinsurance
Indemnity €100.00 (€200.00 – 50%)

G ORTHOPAEDIC IMPLANTS AND HEARING AIDS

The Company shall pay, up to a maximum of €3,000 per family unit per year, expenses for the purchase, repair and replacement of orthopaedic implants and hearing aids.

Payment is also extended to the following, subject to 30% coinsurance, minimum and €50.00 per invoice:

- orthopaedic aids;
- hernia belts;
- curative orthopaedic corsets;
- ocular prostheses;
- hearing aids;
- speech-generating devices;
- mobility aids.

Payment of footwear with inserts, corsets and aesthetic/formative corsets is excluded.

The Company shall pay the expenses incurred for custom-made insoles at specialised centres and upon presentation of a medical certificate and technical documentation; footwear with arch support is not covered

Examples for letter G

Payment scheme
Ceiling €3,000.00
Cost of implants: €200.00
No coinsurance or deductible

Indemnity €200.00

D ENTAL CARE DUE TO ACCIDENTS

The Company pays up to €7,000 per family unit per year for dental treatment in an outpatient dental clinic made necessary by an accident (documented by an Emergency Room certificate issued within 48 hours of the event and occurring within 24 months prior to treatment).

Examples for letter H

Payment scheme
Ceiling €7,000.00
Dental care due to accidents: €400.00
No coinsurance or deductible
Indemnity €400.00

I CO-PAY (Italian National Health Service)

The Company pays in full (without applying any coinsurance) the expenses incurred by way of co-pay for any service covered in this document, up to the maximum limits provided for each individual service.

J ADDITIONAL BENEFITS

Expenses incurred for paediatric visits (up to the age of 14) shall be compensated up to a limit of €1,500 a year per family unit, with a sublimit of €500 a year per person, applying a 30% coinsurance on the cost incurred and documented, whether in-network or out-of-network.

Examples for letter J

Direct care scheme
Ceiling €1,500.00
Paediatric visit fee €70.00
30% coinsurance
Authorised benefit €70.00, of which €49.00 borne by the Company and €21.00 by the Insured

Payment scheme
Ceiling €1,500.00
Paediatric visit fee €70.00
30% coinsurance
Indemnity €49.00 (€70.00 - 30%)

K EYEWEAR

Expenses incurred for the purchase of lenses and eyeglasses (including frames) or corrective contact lenses shall be compensated up to a maximum of €400 per year/family unit and with a sublimit of €150 per person/year, without application of any coinsurance.

The Insured is entitled to indemnity in the event of a first prescription or change in visual acuity, both certified by a duly qualified ophthalmologist, optometrist or orthoptist, for the recovery of socialising activities aimed at promoting active lifestyles.

Examples for letter K

Payment scheme
Ceiling €400.00
Cost of eyeglasses: €60.00
No coinsurance or deductible
Indemnity €60.00

L COMPARATIVE DIAGNOSIS

If one of the following conditions is diagnosed:

- Alzheimer's disease
- AIDS
- Blindness
- Malignant neoplastic diseases
- Cardiovascular diseases
- Deafness
- Kidney failure
- Loss of speech
- Vital organ transplantation
- Neuromotor pathologies
- Multiple Sclerosis
- Paralysis
- Parkinson's disease
- Stroke
- Coma

The Insured may request a review of the case through a diagnostic assessment by leading specialists with the most useful therapeutic indications to treat the identified pathology. In addition, a visit to the specialist who assessed the case may be requested.

Only the expenses incurred by the Insured in connection with the medical consult shall be compensated.

M MATERNITY PACKAGE

Expenses incurred for visits in the first six months of pregnancy shall be compensated without any coinsurance.

In the event of miscarriage/spontaneous abortion, within 3 months of the event, the Company shall pay in full 1 gynaecological visit and a maximum of 3 in-network or out-of-network psychological support visits.

The annual ceiling for all the above services is €500 per family unit.

Examples for letter M

Direct care or payment scheme
Ceiling €500.00
Cost of visit: €100.00
No coinsurance or deductible
Indemnity €100.00

C) ANCILLARY BENEFITS AREA

A EMERGENCY ROOM CARE

The Company shall pay, up to a maximum of €1,000 per event per year, expenses incurred for outpatient care following an accident that did not result in hospitalisation.

Payment includes the costs of the following services (provided they are prescribed by the Emergency Room): plaster application and removal, diagnostic tests, medical care, medicines and transport.

Examples for letter A

Payment scheme
Ceiling €1,000.00
Cost of emergency room service €200.00
No coinsurance or deductible
Indemnity €200.00

B TREATMENT OF DRUG ADDICTS

By way of contribution to expenses incurred for recovery from drug addiction in therapeutic communities affiliated with Local Health Units, the Company shall pay a sum equal to €3,000 per person per year, up to a total of €30,000 per year for all the Insured covered by this policy.

Payment under this cover shall be made in a lump sum at the end of the insurance year.

The deadline for submitting claims for payment under this benefit is 31 January of each year following the year in which the expense for which payment is claimed was incurred. If the total amount of claims exceeds the above annual limit, the amount of €30,000 will be distributed proportionally among those who have submitted claims.

Any claims submitted after 31 January, if eligible and subject to availability, shall be paid within the ceiling of the following year.

C ADVANCE ON HEALTH COSTS

In the case of hospitalisation for Major Surgery (Annex 2) carried out indirectly, an amount up to a maximum of 50% of the expenses to be incurred shall be paid, at the request of the Insured through the Policyholder, and in any case within 50% of the ceiling provided for the type of hospitalisation, without prejudice to the balance after treatment.

Together with the claim for advance payment, the Insured shall produce appropriate medical documentation for the purpose of assessing the effectiveness of the care cover.

D NURSING CARE

The Company shall pay, up to a maximum of €50 per day for a maximum of 90 days per family unit per year, the expenses incurred for medical and nursing care at home, if necessary due to a terminal illness proven by appropriate medical and/or hospital certification.

E REPATRIATION OF BODY

The Company shall pay up to €2,000 per event, the expenses incurred for the transportation of the body to the burial place in Italy, in the event of the death of the Insured following admission (including same-day hospital) to a hospital abroad for illness or injury, with or without surgery, eligible for compensation under the policy.

Costs relating to funeral ceremonies and burial are excluded from payment.

F HOME HOSPITALISATION

The following post-hospitalisation expenses shall be paid in the case of hospitalisation for one of the procedures in the "Major Surgery List" for:

- home hospitalisation (transfer of the patient to a facility managed by a Medical Director), subject to prescription by a Local Health Unit doctor or medical specialist;
- integrated home healthcare (healthcare at home, with the development of a plan of care, with medical, nursing and rehabilitation services), subject to prescription by a Local Health Unit doctor or medical specialist.

Payment of expenses incurred in this capacity is limited to €15,000 per family unit/year, with a maximum of 50 days per hospitalisation:

- without applying coinsurance if carried out in-network;
- applying 10% coinsurance with a minimum of €1,200 per event if not carried out in-network.

G ASSISTED REPRODUCTIVE TECHNOLOGY

The Company shall pay up to €700 per family unit per year, without applying deductibles or coinsurance, for expenses incurred for:

- medical and surgical care related to assisted reproductive technology;
- pharmacological treatments linked to the fertilisation technique used.

Expenses related to the Insured's travel/transfer and any accompanying person's costs are excluded from the payment.

In any case, the daily indemnity in lieu set out under section A "Hospitalisation", letter C "Italian National Health Service" is not recognised for this type of procedure.

H POSTNATAL CARE

The Company shall pay the following benefits aimed at full recovery following childbirth, carried out in affiliated health facilities indicated by the Operations Centre, subject to prior booking:

1. Postpartum psychological support

A maximum of 3 psychological visits will be covered within 3 (three) months of delivery (within the year of cover).

2. Check-up of Lower Limbs

Within 6 (six) months of the birth (in the year of cover), a check-up of the lower limbs may be carried out to determine whether there are any pathological changes in the superficial and deep venous circulation of the lower limbs.

3. Wellness weekends

The following total benefit package is payable within 1 (one) year of childbirth (within the year of cover):

- dietary check-up
- nutritionist consult
- meeting with personal trainer
- basic lesson in exercise education
- spa treatment

I SPA TREATMENTS FOR MINORS

The Company shall pay, up to a maximum of 1 (one) cycle per year (max. 12 consecutive sessions with a break at mid-cycle), for spa treatments, inhalation treatments and Politzer

treatments received by the Insured minor following illness or accident, in affiliated health facilities indicated by the Operations Centre, subject to prior booking.

The costs of the services provided to the Insured shall be paid directly by the Company to the facilities for a maximum amount of €35 per session.

In addition, there is an initial examination and an end-of-care examination with no coinsurance or deductible.

In any case, the hotel costs of the minor and any accompanying person are excluded from the cover.

J DOWN SYNDROME

If Trisomy 21 (Down Syndrome) is diagnosed in the first three years of life, an allowance of €1,000 per infant per year is paid.

The indemnity referred to in this paragraph shall be paid only if the child is included in the cover for a maximum period of 5 years.

K NEWBORNS

The Insurance is understood to be free of charge for newborn babies as long as the Company is notified within 90 days of the birth. It is understood that the cover is also extended to treatment and surgery resulting from malformations and/or congenital physical defects as long as they are carried out within 1 year of birth. However, if the aforementioned malformations and/or congenital physical defects are evident from the first year of life of the newborn child and it is medically and clinically verifiable and documentable that surgery cannot be performed in the first year of life, the period within which surgery is reimbursable - under the terms of the contract - is extended to the first 10 years of life provided that the Insured remains covered.

L HEALTH ACCOUNT

The Health Account is a form of saving for health purposes aimed at ensuring that the family unit saves, for the years following the first, part of the funds available for benefits not used in an insurance year.

CONTO SALUTE

A. Good Health Bonus:

If, during the two-year period, the Insured has a Claims/Contributions ratio for his/her family unit of 75% or less and has carried out the Cassa Uni.C.A. prevention protocols without interruption during the period of cover, an amount equal to 20% of the amount of the contribution for the last year will be automatically credited to their Health Account. This amount may be used to increase the amount of payments requested by the Family Unit in subsequent years, up to the amount of the expense, and/or to reduce the incidence of any amounts payable by the Insured (coinsurance and deductible).

With reference to the calculation of the above ratio:

- "Claims" means the aggregate value of all that the Company has paid during the 2 years by way of indemnity to the Insured persons of the Family Unit, in the form of amounts received for services provided in direct form, reimbursements, daily allowances, and indemnities under this Insurance;
- "Contributions" means the aggregate value of contributions paid by the Insured to the Policyholder during the 2 years for coverage of the Family Unit.

B. Health Savings

If the Family Unit has not been received any indemnity for any healthcare services during the year (with the exception of the Cassa Uni.C.A. prevention protocols, which are not included in this calculation), the Family Unit may request that the savings made during the year be credited to their Health Account to the extent of 10% of the annual contribution.
This amount may be used to increase the amount of payments requested by the Family Unit in subsequent years, up to the amount of the expense, and/or to reduce the incidence of any amounts payable by the Insured (coinsurance and deductible).

M INDEMNITY FOR HEALTH AND CARE COSTS INCURRED FOR PARENTS HOSTED IN A NURSING HOME

The cover provides for the payment of an indemnity, as a lump sum, of €350 per year/person, without applying coinsurance or deductibles, for any medical, healthcare and care expenses incurred by Members for parents admitted to a public or private nursing home as they are not self-sufficient or are no longer able to stay at home due to the impairment, even very serious, of their health and independence.

This benefit is available to Family Units that have not been paid for any healthcare services during the year.

The indemnity shall be paid if the stay in a nursing home has lasted at least 12 consecutive months as from the effective date of this insurance cover.

D) PREVENTION AREA

Before providing any of the services covered in this section, it is advisable to consult your local health unit or your physician about possible contraindications and significant side effects, taking into account the age and state of health of the Insured.

A FOLLOW-UP VISITS

The Company shall pay in full (i.e., without applying any coinsurance or deductible) for each Insured 1 (one) specialist visit in any specialisation carried out once a month and on any day of the week at the facilities affiliated with the Previmedical network, subject to prior booking.

The benefits listed above are also paid in the event of a consult/check-up and therefore no medical or specialist prescription is required in the authorisation stage.

The Insured may receive no more than one visit per month and, if in some months s/he has not received visits, s/he may not request these visits in the following months, adding them to the monthly visit already scheduled.

Example for letter A "Check-ups"

Effective date for this insurance cover: 01/01/2022
Visits to which the insured is entitled during the two-year period: 24, 1 per month
No check-ups in the first 3 months of the year 2022
Remaining check-ups to which the insured is entitled: 21, 1 per month
April 2022: The insured person has a cardiological check-up
Remaining check-ups to which the insured is entitled: 20, 1 per month
May 2022: The insured person has a cardiological check-up
Remaining check-ups to which the insured is entitled: 19, 1 per month

B FLU VACCINE

The Company shall pay in full (without applying any coinsurance or deductible to be borne by the Insured) services for vaccination against the risks of seasonal influenza: one vaccine per year per insured.

The benefit is only paid indirectly on presentation of a copy of the invoice or receipt.

C HERPES ZOSTER PREVENTION

The Company will pay for services for the prevention of herpes zoster and its complications for all Insured over 55 years of age carried out either in-network at facilities affiliated with the Previmedical network (subject to prior booking) or under payment scheme.

The services listed above are considered as preventive treatment and therefore no medical or specialist prescription is required at the authorisation stage.

A deductible of €36.15 per hospitalisation is provided.

D PAEDIATRIC CHECK-UP

Paediatric specialist follow-up visit. The visit is carried out at affiliated health facilities for the Insured minors present in the Family Unit and previously included in the cover, at the following conditions and age:

- 1 (one) visit between 6 months and 12 months of age
- 1 (one) visit at 4 years of age
- 1 (one) visit at 6 years of age

The benefits listed above are paid in the event of a consult/check-up and therefore no medical or specialist prescription is required in the authorisation stage.

The costs of the services provided to the Insured shall be paid directly by the Company to the healthcare facilities, applying a deductible of €36.15 per service.

E NUTRITIONAL CHECK-UP AND PERSONALISED DIET

This insurance covers the cost of one consult and personalised diet every two years of insurance per person.

When using affiliated healthcare facilities, the annual spending limit for this cover is unlimited.

If non-affiliated healthcare facilities are used, the total annual expense limit available for this cover is €80 per person for two-year period, of which €50 is for the visit and €30 is for the diet.

F STEM CELL PRESERVATION

The Company shall pay up to €500 per family unit per year, without applying deductibles or coinsurance, the expenses incurred for the autologous preservation of the family's umbilical cord stem cells, both in-network and out-of-network.

EXTRA

CHAPTER 2 - EXCLUSIONS AND LIMITS

Article 18. Exclusions

The following are excluded from cover:

1) relating to the correction or elimination of myopia, except as provided for under section A "Hospitalisation", letter A), item 9
2) dentures, paradontopathies, dental treatments and dental examinations, except as provided for under section A "Hospitalisation", letter A), item 8 and under section B "Specialist and/or outpatient out-of-hospital care area", letter H
3) medical services for aesthetic purposes, except for the following plastic surgery procedures:
   - surgery, including cosmetic surgery, for children under the age of three;
   - surgery following an accident eligible for compensation under the policy;
   - reconstructive surgery following demolitive procedures or cancer surgery (limited to the anatomical site of injury) eligible for compensation under the policy;
   - contralateral adjustment procedures related to reconstructive surgery following mastectomy or quadrantectomy under the sub-ceiling provided for under section A "Hospitalisation", letter A), item 10
4) hospitalisation during which only physical examinations or therapies, which, due to their technical nature, can also be carried out in an outpatient clinic, are carried out provided that this is permitted by the state of health of the Insured;
5) hospitalisation caused by the need for the Insured to receive care from third parties in order to carry out the elementary acts of daily life, as well as long-term hospitalisation, determined by the physical conditions of the Insured that no longer allow recovery with medical treatment and that make it necessary to stay in a nursing home for care or maintenance physical therapy;
6) intoxications and injuries resulting from:
   - alcohol abuse;
   - use of hallucinogens;
   - non-therapeutic use of psychotropic drugs and narcotics;
7) voluntary non-therapeutic abortion;
8) the correction or elimination of malformations or physical defects, unless they result from a pathology or are the consequence of an accident, and without prejudice to the provisions under section C "Ancillary Benefits Area", letter K "Newborns";
9) all procedures and interventions for the purpose of assisted reproduction, except for the provisions of the cover under section C "Ancillary Benefits Area", letter G "Assisted Reproductive Technology". In any case, the daily indemnity in lieu set out under section A "Hospitalisation", letter C "Italian National Health Service" is not recognised for this type of procedure;
10) injuries suffered as a result of the Insured's own criminal actions wilfully carried out or attempted, as well as deliberately carried out or permitted against his/her person;
11) clinical check-ups;

12) physical therapy services (where applicable) not provided by a medical specialist or by a professional with a degree in physical therapy or an equivalent qualification recognised in Italy, or provided in beauty or fitness centres;
13) the direct or indirect consequences of transmutation of the nucleus of the atom as well as of radiation caused by the artificial acceleration of atomic particles;
14) the consequences of war, insurrections, earthquakes and volcanic eruptions;
15) accidents resulting from the practice of air sports in general or any sport practised professionally;
16) accidents resulting from participation in races or competitions in cars that are not purely regularity races, or in motorbikes and motorboats, as well as related trials and training;
17) injuries sustained and illnesses occurring during the performance of military service or service in lieu thereof, voluntary enlistment, recall for mobilisation or for exceptional reasons;
18) expenses incurred as a result of the following mental illnesses: psychosis, neurotic personality disorders and other non-psychotic mental disorders, mental retardation and in any case all illnesses included in chapter 5 (MENTAL DISORDERS) of the 9th revision of the International Classification of Diseases (ICD9-CM) of the World Health Organisation and/or the taking of psychotropic drugs for therapeutic purposes;
19) services provided in convalescent and residential homes, health camps and nursing homes for dietary and aesthetic purposes or long-term care facilities, insofar as they are not considered "healthcare facilities", as well as gyms, gymnastic and sports clubs, beauty studios, health hotels, medical hotels, and wellness centres even if they have an annexed medical centre.

Article 19. Non-insurable Persons

New insured who have already reached the age of 85 on 31 December 2021 are not permitted to join the policy.

However, individuals who were already covered under the previous health plan and who turn 85 during the term of the contract may continue to be insured until 31 December 2023.

Up to the age limit for this cover, mentally handicapped persons or persons taking psychotropic medications for therapeutic purposes will also be eligible for cover, subject to the provisions of Article 21 "Exclusions".

CHAPTER 3 - PAYMENT OF INDEMNITY

Article 20. Charges in the event of a claim and procedures to access services

20.1 Charges

Claim
The claim must be reported by the Insured or his/her assignees to the Company as soon as they have the opportunity to do so, and in any case within and not beyond the terms of limitation of the right. Failure to comply with this obligation may result in the total or partial loss of the right to payment of the expenses incurred, pursuant to Article 1915 of the Italian Civil Code.
If essential elements are missing, and the Insured is unable to make them available to the Company, the claim cannot be presented and is therefore rejected. "Claim" means a request for access to the Network to use services under the direct care scheme or to obtain Reimbursement or Indemnity (however named).
The Operations Centre avails itself of medical consultants in order to correctly frame the service requested from among the contractually provided covers. The medical consultants of the Operations Centre do not enter into the merits of the medical request (i.e., they do not evaluate the suitability of the plan of care prescribed by the attending doctor for the treatment of the pathology of the Insured), but simply ascertain that it is a covered Claim.

The Company shall reject a claim in the following cases in which the essential elements mentioned below are deemed to be lacking:

Direct care
- cover not included
- pathology missing or inconsistent with the service
- no documentation at all or illegible documentation
- no cover
- non-affiliated healthcare facility/physician or service not covered by agreement
- failure to indicate the affiliated facility or doctor
- expired medical prescription
- no indication of the service to be provided
- Depleted ceiling
- filing of multiple requests for the same service
- cancellation of the request for authorisation by the Insured

Reimbursement/Indemnity Compensation Scheme
- cover not included
- pathology missing or inconsistent with the service
- no documentation at all or illegible documentation
- no cover
- incorrect request entry

- expired medical prescription
- Depleted ceiling
- submitting a new claim for an invoice that has already been submitted for reimbursement/settled
- submitting a claim that has already been requested/settled
- cancellation of the claim by the Insured

The Company shall require the Insured to supplement the claim if:
- The supporting documentation is incomplete (e.g.: Medical record without hospital discharge form or not transmitted in certified copy or, in case of Outpatient Procedure, failure to send the medical report; no intraoral x-ray and photo materials for dental services; no emergency room certificate in case of services related to the Accident)
- the Insured to whom the Claim relates has not been correctly indicated. If the Insured fails to supplement the Claim within 60 calendar days of the Company's request for supplementation, the claim shall be rejected; the application can still be resubmitted.

Date of Claim
- Hospital services: the date of Hospitalisation or, if there was no Hospitalisation, of the same-day hospitalisation or of the outpatient surgical procedure
- out-of-hospital services: the date of the first medical service provided relating to the specific event
- physical therapy and dental services: the date of execution of the single service.

Reimbursement by Funds, Agencies or other Companies
If the Insured receives reimbursement from Funds, Agencies or other insurance companies, s/he must send the statement of settlement of the individual services from such entities and photocopies of the invoices relating to the reimbursement.

Language of documentation
Documentation drawn up in a language other than Italian, English, French or German must be accompanied by a translation into Italian. If there is no translation, any costs to translate it shall be borne by the Insured.

Visits by doctors commissioned by Intesa Sanpaolo RBM Salute
The Insured, his/her family members or assignees must allow visits by the Company's doctors and any investigations or checks that the Company may deem necessary; for this purpose they shall release the doctors who have examined and treated the Insured from doctor-patient confidentiality.
The assessment may be ordered
- not earlier than 48 hours after the claim has been filed
- within no more than 6 months from the acquisition of the complete documentation relating to the claim.

Death of the Insured

If during the validity of cover the Insured dies,

- his legal heirs shall promptly notify the Company
- the obligations provided for in this article must be fulfilled by the heirs entitled to claim reimbursement for claims made or yet to be made up to the expiry of the cover.

In this case, other documents must be submitted such as:

- death certificate of the Insured,
- certified copy of any will, or declaration in lieu of affidavit, with:
  - details of the will
  - declaration if the will is the last valid and has not been challenged
  - indication of the heirs to the will, their ages and capacity to act;
- if there is no will: a declaration in lieu of affidavit (in the original or certified copy) made by the interested party before a public official proving that:
  - the Insured died without leaving a will,
  - the personal details, age and capacity to act of the legitimate heirs,
  - that there are no other persons to whom the law attributes rights or shares of the estate
- if there are beneficiaries who are minors or lacking capacity: certified copy of the decree of the judge supervising a guardianship authorising the Intesa Sanpaolo RBM Salute to liquidate the capital and the beneficiaries to collect their shares
- photocopy of a valid ID document and tax/health insurance card of each heir
- declaration signed by all the heirs, indicating the IBAN code of a single current account to which the transfers relating to the payment of claims filed or still to be filed up to the expiry of the cover as regulated in this Contract.

These provisions do not apply to the indemnity in lieu which is not transferable to the heirs in the event of the death of the Insured prior to resignation.

Private services at public facilities:

Services are considered private even if they are provided in public facilities.

Services between two insurance years

Services provided between two insurance years are included in the ceiling amount for the year in which the service is provided.
No invoices are allowed on account.

Pre- and post-inpatient/same-day hospitalisation expense limits

The expense limits (e.g., Deductible/Coinsurance/minimum not eligible for compensation) applied to expenses before and after inpatient/same-day hospitalisation are those provided under Hospitalisation cover, which differ according to the scheme for access to the single service chosen (Direct or Reimbursement).
Under Direct scheme, in the event that Hospitalisation does not take place, the services authorised as pre-hospitalisation are considered as out-of-hospital services, if provided for by the Contract. The Insurant is obliged to return to the Company, on written request, any amounts to be borne by the Insured deriving from the application of a different cover (e.g.,

due to a higher deductible or coinsurance or, in the case of a service not provided for, for the entire cost thereof). In the event that the service could not be included in the out-of-hospital services, the Insured is obliged, at the request of the Company, to reimburse the entire sum paid by the Company to the Affiliated Facility or to pay directly the amount due to the Affiliated Facility if the Company had not yet made the payment.

Taxes and administrative fees

The following shall be borne by the Insured:

- taxes and stamps
- administrative fees of any kind (e.g., for issuing copies of medical records).

20.2 Procedure to access services - Direct or mixed care scheme

a) Before the service

The Insured shall:

- collect all the documentation required, if requested by these TCI, to perform the service under the Direct scheme (e.g., medical prescription with indication of the pathology);

- select the affiliated healthcare facility where the service is to be provided, by accessing the reserved area or mobile App, as well as by telephone contact with the Operations Centre (available **24 hours a day, 365 days a year)**. The Network is constantly evolving and affiliated facilities may change even during the period of cover. The list of affiliated facilities is available on the website www.intesasanpaolorbmsalute.it or mobile App;

- contact the selected Network facility and book the service to be provided;

- ask the Company for authorisation to provide the service booked, attaching all the required documentation (in the event of a telephone call, the operators will explain to the Insured how to send the documentation), with at least 48 working hours notice before the day on which the service will be provided.

It should be noted that, including for dental services, the Insured must from time to time request individual authorisation for each service to be provided, and that requests for authorisation received directly from dental practices shall not be considered.

Limited to physical therapy services, the Insured must request authorisation only for the first service provided for by the course of therapy or treatment plan; The remaining authorisations are instead requested directly by the Network's healthcare facility.

Authorisation may be requested through:

- mobile app
- web portal
- dedicated telephone numbers:
  - **800. 90.12.23** from landline and mobile phones (freephone)
  - **+39 0422.17.44.023** for calls from abroad.

Details to be provided

- surname and first name, date of birth and telephone of the Insured who needs the service;
- healthcare facility where the service is provided;
- service to be provided;
- date of the service
- diagnosis or diagnostic question.

Documents to be sent

- **valid medical prescription** (including electronic medical prescription) in accordance with the regional regulations in force from time to time, containing the diagnostic question/diagnosis and the pathology for which the specified service is required.

A prescription is not required for preventive services (health and dental).

The prescription must be drawn up by a doctor other than the medical specialist who will (directly or indirectly) provide the service, or, if the prescribing doctor is also the provider of the services performed, the services must be certified by transmission of the relevant report.

For services other than hospitalisation, we may consider that reading the prescription is sufficient and do not require the prescription to be transmitted at this stage.

- **In the event of an accident, the following documents must also be submitted:**

• emergency room report within 48 hours of the event, as the accident must be objectively documented. If there are no Emergency Rooms in the place where the accident occurred, the Insured may submit a certificate issued by a substitute public medical facility (drawn up within 48 hours of the event).

In the case of dental treatment due to an accident, the treatment must be consistent with the injuries sustained and the accident must be objectively proven with suitable supporting documentation (emergency room report, OPT, X-rays and photographs).

For this insurance cover to be operative, the circumstance that the Emergency Room report contains the term "accident" does not in itself determine the eligibility of the claim to be paid under the policy; In order to determine whether there is an accident or not according to the policy it is necessary to examine what is written in the Emergency Room certificate and in the supplementary medical documentation, if any. Situations in which fortuitous, violent, and external illnesses and events coexist must be evaluated on a case-by-case basis in light of the medical documentation submitted.

- **if the damaging event is attributable to the responsibility of a third party, also the name and address of the third party responsible. In the event of a road accident** - at the same time as the first request for direct healthcare, regarding medical services that have become necessary as a result of the accident **- the Insured is required to also send the Company the accident report drawn up by the police or the CID Form** (amicable accident report).

- **certificate issued by a duly qualified ophthalmologist or optometrist**, certifying the change in visual acuity, in the case of the purchase of lenses, excluding disposable lenses. Please note that it should be specified whether this is a prescription for first lenses; please also note that it is necessary to submit the certificate of conformity issued by the optician, as per Italian Legislative Decree no. 46 of 24/02/97
- **in case of physical therapy treatments:**
    - prescription by a medical specialist whose specialisation is inherent to the reported pathology;
    - indication of the doctor's specialisation, or of the qualification of the professional who provided the service.

The Company may request further documents if there are particular situations that make it necessary to carry out in-depth assessments and evaluations before settling the claim, for particular investigative requirements or to comply with specific legal provisions.

How to submit the documents:
- via web portal or mobile app
- by fax: **+ 0422.17.44.523**
- by replying to the e-mail received from the Operations Centre (in case of direct contact with the latter)

If the Operations Centre has positively concluded the administrative, medical and insurance checks on the request made, the authorisation for direct services shall be sent to the Insured **via e-mail or text message** and simultaneously also to the identified affiliated facility. The Insured shall indicate at the time of requesting the medical service whether the authorisation is to be received by text message or e-mail. If the Insured does not have a smartphone, in order to access the healthcare facility, s/he must choose e-mail as the means of receiving the authorisation and, if necessary, print it from any PC.

The text message or email will have a short web link (so-called "tiny link") that will allow the authorisation to be displayed on the device's screen.

The Company will make direct payment of the expenses eligible for compensation under the policy according to the terms of the agreement concluded with the affiliated nursing homes, professionals and clinical centres.

If the Insured are interested in a healthcare facility that is not currently part of the Network made available to them, they may indicate such an entity in order to assess the possibility of affiliation; to this end, it will be sufficient to propose the facility to the Company, sending the request to the following e-mail address: ufficio.convenzioni@intesasanpaolorbmsalute.it

Subject to the minimum notice period of 2 working days (48 hours), the Operations Centre guarantees the response (authorisation/denial) on the outcome of the assessment of the direct care request:

For hospital services:

- if the request is received at least 7 working days before the date of the event, the Operations Centre guarantees a response within 2 working days of the Insured's request
- if the request is received between 6 and 4 working days before the date of the event, the Operations Centre guarantees a response within 2 working days before the date of the event
- if the request is received between 3 and 2 working days before the date of the event, the Operations Centre guarantees a response within 1 working day before the date of the event.

For out-of-hospital services:

- if the request is received at least 4 working days before the date of the event, the Operations Centre guarantees a response within 2 working days before the date of the event
- if the request is received between 3 and 2 working days before the date of the event, the Operations Centre guarantees a response within 1 working day before the date of the event.

This does not affect the Insured's right to give at least 2 working days' (48 hours) advance notice; however, in this case, this minimum advance notice could result in the Operations Centre notifying the Insured, should the authorisation be denied, close to the time scheduled for the use of the service.

In any case, it should be noted that during the start-up phase of the Health Plans, it may not be possible to comply with the aforementioned service levels until the process of acquiring personal data is completed. To this end, all the Insured who intend to make use of a direct care service are invited to contact the Operations Centre as soon as possible.

During access to the affiliated Healthcare Facility, the Insured, in order to receive the authorised service, shall present the authorisation received from the Operations Centre and submit the medical prescription.

The Insured must notify the Operations Centre in advance of any changes and/or additions to the authorised service, so that the new authorisation can be issued, once the necessary administrative and technical/medical checks have been successfully completed.

The waiver of the need to request prior authorisation from the Operations Centre to activate the direct care scheme and in any case for access to affiliated healthcare facilities is provided only for the emergency cases referred to in paragraph b) below.

Any sums not recognised by these terms and conditions of insurance (e.g. deductibles and coinsurance) shall be borne by the Insured.

b) Failure to activate the Operations Centre

If the Insured gains access to affiliated Healthcare facilities without complying with the obligations of prior activation of the Operations Centre, with the exception of cases of medical and health emergencies (only for Hospitalisation cover), s/he may file a claim with the Company only if provided for by the relative cover and at the specific terms and conditions established therein (e.g., coinsurance or deductible). Outside of these cases, the expenses for the service rendered shall be borne solely by the Insured.

c) After the service

Once the service has been rendered, the Insured must countersign the invoice issued by the affiliated facility, which shall indicate the amount to be paid by the Insured (for any services not covered by the Terms and Conditions of Insurance).
Direct payment of expenses, within the terms set out in the Terms and Conditions of Insurance, shall be made upon receipt by the healthcare facility of the invoice and the medical documentation requested from the Insured and/or the healthcare facility (e.g., medical record).

d) Exception: cases of medical urgency (for Hospitalisation cover only)

If it is absolutely impossible to contact the Operations Centre in advance, limited to pathologies/illnesses in an acute phase or in the case of objectively ascertainable physical injuries produced by an event due to a fortuitous, violent and external cause,

- the Insured or other authorised person may request authorisation within 5 days of the start of hospitalisation and in any case before being discharged from the affiliated facility, if less days have passed
- the Insured or other authorised person contacts the Operations Centre which sends a form to be filled out by the health facility where the Insured is hospitalised
- **the form, once completed, is to be returned to the Operations Centre** (by replying to the email received from the Operations Centre or by fax **0422.17.44.523**) **attaching** the report of the doctor who ordered emergency hospitalisation or, in case of accident, the report of the Emergency Room, drawn up within 24 hours of the event.

The final assessment of whether or not the case is actually serious is carried out by the Operations Centre; the activation of the urgency procedure is subject to this assessment.
The urgency procedure cannot be activated for hospitalisations under direct care abroad, for which the Insured must always receive prior authorisation from the Operations Centre.

EXTRA

20.3 Procedure to access services - Payment scheme

a) Hardcopy claim application

In order to obtain compensation as soon as the complete medical documentation is available, the Insured may complete the Claim Form (www.intesasanpaolorbmsalute.com, section Group Health Policies – Forms). In the event that this form is not used, the Intesa Sanpaolo RBM Salute will accept the claim application only if all the information on the form is provided in full (including the "Consent to the personal data processing pursuant to the relevant legislation in force", to be signed with a specific signature in addition to that placed at the bottom of the claim application). In any case, the Insured must attach copies of the following documents to the claim application:

1. **receipted expense documentation** (invoices, bills, receipts), issued by a healthcare facility or medical centre. Invoices issued by medical practices or specialists must clearly and legibly indicate the professional's specialisation, which must be consistent with the diagnosis. **All documentation must be fiscally compliant with current legislation. For the payment of expenses incurred for healthcare services under the Italian National Health Service, the invoice or receipt issued at the time of payment by the Local Health Unit or healthcare facility accredited with the Italian National Health Service is required, or the payment receipt issued by Punto Giallo with the booking sheet issued by the Local Health Unit at the time of booking or when the service was provided. The provider will check that the service (which can be found in the appropriate code contained in the aforementioned documents) is one of those provided for by the Health Plan (e.g., expenses incurred for prevention and/or control services are excluded). In order to be able to consider the services as performed under the Italian National Health System co-payment scheme, with the application of the relevant settlement conditions, it is necessary that the expenditure document unequivocally indicates the payment scheme.**
2. **complete medical records and hospital discharge form (HDS), in the event of hospitalisation, including Same-Day Treatment. Please note that a stay in the Emergency Room is not considered a hospitalisation or Same-Day Treatment;**
3. **valid medical prescription** (including electronic) in accordance with the regional regulations in force at the time, stating the nature of the pathology and the services provided, in the case of non-hospital benefits;
4. **detailed medical report stating the nature of the pathology and the services carried out, in the case of outpatient procedure, with a histological report, if any;**
5. **certificate issued by a duly qualified ophthalmologist or optometrist, certifying the change in visual acuity, in the case of the purchase of lenses, excluding disposable lenses. Please note that it should be specified whether this is a prescription for first lenses; please also note that it is necessary to submit the certificate of conformity issued by the optician, as per Italian Legislative Decree no. 46 of 24/02/97;**
6. **Claims for dental treatment must be submitted at the end of the treatment plan**, unless the plan is longer than one year. In this case, the cost estimate must be submitted with the first claim;
7. **in case of physical therapy treatments:**

I. prescription by a medical specialist whose specialisation is inherent to the reported pathology;
II. indication of the doctor's specialisation, or of the qualification of the professional who provided the service.

Payment claims for physical therapy treatment must be submitted at the end of the treatment.

8. for **Mixed scheme** services: The Insured shall also submit:
   - A form signed by the Affiliated Facility attesting to payment for services by the non-affiliated team, or
   - proof of payment of the medical fees (e.g., copy of bank transfer)
9. **In the event of an accident, the following documents must also be submitted:**
   - emergency room report within 48 hours of the event, as the accident must be objectively documented. If there are no Emergency Rooms in the place where the accident occurred, the Insured may submit a certificate issued by a substitute public medical facility (drawn up within 48 hours of the event).
     In the case of dental treatment due to an accident, the treatment must be consistent with the injuries sustained and the accident must be objectively proven with suitable supporting documentation (emergency room report, OPT, X-rays and photographs); For this insurance cover to be operative, the circumstance that the Emergency Room report contains the term "accident" does not in itself determine the eligibility of the claim to be paid under the policy; In order to determine whether there is an accident or not according to the policy it is necessary to examine what is written in the Emergency Room certificate and in the supplementary medical documentation, if any. Situations in which fortuitous, violent, and external illnesses and events coexist must be evaluated on a case-by-case basis in light of the medical documentation submitted.
   - **if the damaging event is attributable to the responsibility of a third party, also the name and address of the third party responsible.**
     In the event of a road accident - at the same time as the first payment claim regarding medical services that have become necessary as a result of the accident - **the Insured is required to also send the Company the accident report drawn up by the police or the CID Form** (amicable accident report);

The Company may request further documents if there are particular situations that make it necessary to carry out in-depth assessments and evaluations before settling the claim, for particular investigative requirements or to comply with specific legal provisions.

The form and its annexes should be sent to the following address:

PREVIMEDICAL C/O CSU – BOLOGNA (INTERNAL MAIL)

or

Ufficio Liquidazioni UNI.C.A. - PREVIMEDICAL

Casella Postale n. 142

31021 Mogliano Veneto (TV)

The documentation must be in the name of the Insured and the payment will be made to the covered Insured.

For the purposes of the due payment, all insured services must be prescribed by a doctor other than the doctor who will - directly or indirectly - provide the said services.

If the prescribing doctor is also - directly or indirectly - the doctor providing the insured services, the latter must be certified by sending the relevant report.

The services must be provided by specialised personnel (doctor, nurse), accompanied by the relevant diagnosis (indication of the pathology or suspected pathology), and invoiced by a healthcare facility or medical centre. Invoices issued by medical practices or specialists must clearly and legibly indicate the professional's specialisation, which must be consistent with the diagnosis.

For the purposes of a correct evaluation of the claim or to verify the truthfulness of the documentation produced in copy, the Company shall always have the right to request the production of the originals of the aforementioned documentation.

b) Online payment claim

As an alternative to the hardcopy claim procedure, the Insured may submit their claim online, together with the relative medical and expense documentation. To this end, the Insured must access his/her Reserved Area at the website www.unica.previmedical.it (Reserved Area) or through the Mobile App.

Documentation will be submitted using an optical scanning system, which the Company considers legally equivalent to the original for the purposes of applying this cover. The Company reserves the right to carry out all the necessary checks with doctors and healthcare facilities in order to prevent possible abuse of this channel.

For those who do not have access to the Internet, payment claims may be made through the traditional channel (hardcopy), as described in the previous paragraph.

Return of amounts unduly paid

In the event of hospitalisation in a direct care facility, if, either during or after hospitalisation, it is ascertained that the policy is not valid or that there are conditions or elements that determine the inoperability of the benefit or the ineffectiveness of the insurance cover, the Company shall notify the Insured in writing, who shall return to the Company all sums unduly paid by the latter to the medical facility, if already paid by the Company to the affiliated facility and/or doctors, or shall pay both the affiliated facility and doctors directly.

EXTRA

INTESA SANPAOLO RBM SALUTE

Re-settlement of cases following a change in classification in the underwriting stage or in the second year of cover

In the event that, by the deadline of 30 April, the Insured is entitled to use a policy other than the one initially allocated to him/her, with effect from the start of the reference calendar year, the claim already settled (directly or indirectly) under the policy initially allocated to him/her shall be paid if the provisions of the policy to which s/he is entitled from the start of the reference calendar year are different, for the claim in question, from those of the policy initially allocated.

In that case:

- any differences due the Insured shall be paid by the Company;
- any differences due to the Company shall be paid back by the Insured.

Any such differences shall be settled, by the Company or the Insured, by 30 June of the reference year.

The Policyholder expressly approves the provisions of articles[6]:

Article 6 - Declarations on circumstances concerning risk - Health Questionnaire
Article 7 - Commencement of Insurance – Tacit Renewal – Right to withdraw
Article 8 - Underwriting of Cover – Change of the Insured
Article 14 - Jurisdiction
Article 18 - Exclusions
Article 19 - Non-insurable Persons
Article 20 - Charges in the event of a claim and procedures to access services

Intesa Sanpaolo RBM Salute S.p.A.
Marco Vecchietti
Amministratore Delegato e Direttore Generale

Cassa Uni.C.A.

[6] Article 1341 "General Terms and Conditions of Contract" of the Italian Civil Code.

Annex 1 – List of surgical procedures with ceilings

TYPE OF SURGERY	CEILING
Vein (including varicocele) ligation and stripping	EUR 3,500
Functional septoplasty, including possible surgery on turbinates	EUR 3,500
Surgery for reduction and synthesis of fractures of large segments (femur, humerus, tibia)	EUR 9,000
Surgery for reduction and synthesis of fractures of medium segments (clavicle, sternum, patella, radius, ulna, fibula)	EUR 6,000
Surgery for reduction and synthesis of fractures of small segments (all others)	EUR 3,000
Surgery for removal of synthesis media (for example, nails, plates, screws)	EUR 3,000
Tonsillectomy / adenotonsillectomy	EUR 3,000
Surgery for hernias and/or incisional hernias of the abdominal wall	EUR 5,000
Hemorrhoidectomy and/or surgery for the removal of fissures and/or fistulas and/or rectal prolapse	EUR 4,500
Surgery for hallux valgus with or without metatarsophalangeal realignment, hammer toe, stiff toe	EUR 4,000
Knee surgery (other than on ligaments)	EUR 7,000
Surgical hysteroscopy	EUR 4,000
Ligament reconstruction surgery	EUR 8,500
Rotator cuff surgery	EUR 7,500
Ovarian cyst removal surgery	EUR 8,500
Thyroidectomy (excluding radical surgery for malignant cancer)	EUR 10,000
Cholecystectomy	EUR 8,500
Herniated disc and/or vertebral stabilisation surgery	EUR 11,000
Arthrodesis and/or vertebral stabilisation surgery (any method), including possible excision of intervertebral herniated disc (any method)	EUR 14,000
Endoscopic prostatectomy for adenoma (transurethral resection of the prostate)	EUR 9,000
Radical prostatectomy for malignant cancer including lymphadenectomy (any method, including robot)	EUR 18,000
Hysterectomy	EUR 10,000
Hysterectomy for malignant cancer (including possible removal of uterine adnexa and lymphadenectomy)	EUR 15,000
Hip replacement surgery	EUR 20,000
Excision of skin neoformations (cysts in general, lipomas and nevi)	EUR 1,000
Knee replacement surgery	EUR 15,000
Surgery for Dupuytren's disease, Guyon's syndrome	EUR 2,000

EXTRA

Carpal tunnel surgery	EUR 1,500
Surgery for snap finger and entrapment of the ulnar nerve at the elbow	EUR 2,500
Cataract surgery (with or without intraocular lens implantation) - per eye	EUR 2,000
Surgery for removal of benign breast cysts and nodules (nodulectomies)	EUR 3,500
Appendectomy	EUR 4,000
Paranasal, frontal and maxillary sinus surgery and/or functional endoscopic sinus surgery	EUR 3,500

EXTRA

Annex 2 – List of Major Surgical Procedures

OESOPHAGUS SURGERY

- Cervical oesophagus: resection with reconstruction with intestinal loop auto transplantation
- Median oesophagectomy with two- or three-field access (thoraco-laparotomic or thoraco-laparoscopic-cervicotomic) with intrathoracic or cervical oesophagoplasty and lymphadenectomy
- Osophagogastroplasty, oesophagojejunalplasty, oesophagocolonplasty
- Closed-chest oesophagectomy with neck oesophagoplasty and lymphadenectomy
- Oesophagectomy by thoracoscopic route
- Enucleation of leiomyomas of the thoracic oesophagus by conventional route WITH THORACOTOMY
- Azygos-portal disconnections by abdominal and/or transthoracic route for oesophageal varices.

STOMACH-DUODENUM-SMALL INTESTINE SURGERY

- Total gastrectomy with lymphadenectomy
- Proximal gastrectomy and subtotal oesophagectomy for carcinoma of the cardia
- Total gastrectomy and distal oesophagectomy for carcinoma of the cardia

COLON SURGERY

- Right hemicolectomy and lymphadenectomy
- Total colectomy with ileum-rectum-anastomosis without or with ileostomy
- Anterior resection of the rectum and colon and lymphadenectomy by conventional route
- Resection of the rectum and colon with coloanal anastomosis by conventional route
- Proctocolectomy with ileo-anal anastomosis and ileal reservoir by conventional route
- Amputation of the rectum by the abdomino-perineal route

LIVER AND BILIARY TRACT SURGERY

- Liver resections for biliary tract cancer
- Portal hypertension surgery:

a) Derivation procedures

- portacaval anastomosis
- splenorenal anastomosis
- mesenteric-caval anastomosis

b) Devascularisation procedures

- ligation of varicose veins by thoracic and/or abdominal route
- oesophageal transection by thoracic route

EXTRA

- oesophageal transection by abdominal route
- azygos-portal disconnection with gastrojejunal anastomosis
- oesophageal transection with paraoesophageal-gastric devascularisation

PANCREAS SURGERY

- Pancreaticoduodenectomy with or without lymphadenectomy
- Total pancreatectomy with or without lymphadenectomy
- Surgery for functional endocrine tumours and malignant neoplasms of the pancreas

NECK SURGERY

- Total thyroidectomy for malignant neoplasms without or with mono or bilateral laterocervical emptying
- Tracheal resections and plastic surgery
- Total pharyngo-laryngo-oesophagectomy with pharyngoplasty for hypopharynx and cervical oesophageal carcinoma

THORACIC SURGERY

- Surgical excision of cysts and tumours of the mediastinum
- Lobectomies, bilobectomies and pneumonectomies
- Pleurectomies and pleuropneumonectomies
- Lobectomies and segmental or atypical resections by thoracoscopic route
- Bronchial resections with replantation
- Thoracoplasty: 1st and 2nd stage

HEART SURGERY

- Aortocoronary bypass
- Surgery for congenital heart disease or malformations of large vessels (not excluded from the guarantee)
- Cardiac resection
- Valve replacement with prosthesis
- Valvuloplasty

VASCULAR SURGERY

- Thoracic and/or abdominal aorta surgery BY THORACOABDOMINAL ROUTE
- Abdominal aorta and iliac arteries (mono or bilateral) surgery BY LAPAROTOMY
- Treatment of traumatic aortic lesions
- Treatment of traumatic lesions of the limb and neck arteries
- Aortoenteric fistula surgery
- Superior or inferior vena cava surgery

EXTRA

NEUROSURGERY

- Craniotomy for vascular malformations (not excluded from the guarantee)
- Craniotomy for spontaneous intracerebral hematoma
- Craniotomy for intracerebral hematoma due to vascular malformation rupture (not excluded from the guarantee)
- Craniotomy for endocranial neoplasms above and below the tentorium cerebelli
- Craniotomy for intraventricular neoplasms
- Transsphenoidal approach for neoplasms of the pituitary region
- Brain biopsy by stereotaxic route
- Orbital tumour excision by intracranial route
- Internal and external ventricular derivation
- Craniotomy for cerebral access
- Surgery for cervical disc herniation or cervical myelopathy and radiculopathy by anterior route
- Surgery for malignant neoplasms of peripheral nerves

UROLOGICAL SURGERY

- Expanded nephrectomy
- Nephroureterectomy
- Urinary diversion with intestinal interposition
- Total cystectomy with urinary diversion and orthotopic or heterotopic neobladder with intestinal segment
- Augmentation enterocystoplasty
- Orchiectomy with pelvic and/or lumbar aortic lymphadenectomy
- Total amputation of the penis and lymphadenectomy total emasculation, for malignant neoplasm
-

GYNAECOLOGICAL SURGERY

- Extended vulvectomy with lymphadenectomy
- Radical hysterectomy by abdominal route with lymphadenectomy

EYE SURGERY

- Full thickness corneal transplant
- Eyeball neoplasm surgery

EAR, NOSE AND THROAT SURGERY

- Parotid excision for malignant neoplasms with emptying
- Extensive demolition surgery for malignant neoplasms of the tongue, oral cavity floor and tonsil with ganglion emptying

EXTRA

- Surgery for functional recovery of the VII cranial nerve
- Excision of neurinoma of the eighth cranial nerve.
- Petrosectomy

ORTHOPAEDIC SURGERY

- Vertebral arthrodesis by anterior route
- Shoulder replacement surgery
- Hemi-pelvic fracture reconstruction-osteosynthesis
- Hemipelvectomy
- Surgical reduction and stabilisation of spondylolisthesis
- Surgical treatment of bone tumours
- Major limb amputations exceeding one third

MAXILLOFACIAL SURGERY

- Resection of the maxilla due to neoplasm
- Resection of the mandible due to neoplasm

PAEDIATRIC SURGERY (NOT EXCLUDED FROM THE GUARANTEE)

- Bifid skull with meningoencephalocele
- Hypersecretory hydrocephalus
- Cystic and polycystic lung (lobectomy, pneumonectomy)
- Typical child cysts and tumours of enterogenic bronchial and nervous origin (neuroblastoma)
- Congenital oesophageal atresia
- Congenital oesophageal fistula
- Funnel chest and pigeon chest
- Congenital pyloric stenosis
- Intestinal obstruction of the newborn due to meconium ileus: resection with primary anastomosis
- Simple anal atresia: abdominoperineal lowering
- Anal atresia with recto-urethral or recto-vulvar fistula: abdominoperineal lowering
- Megaureter: resection with reimplantation, resection with intestinal loop replacement
- Megacolon: Buhamel's or Swenson's abdominoperineal surgery
- Nephrectomy due to Wilms' tumour
- Spina bifida: meningocele or myelomeningocele

OTHER ITEMS

The following are also considered "major surgical procedures":

- organ transplantation with donor organ removal;

EXTRA

- admission to the intensive care unit (so-called resuscitation), provided it exceeds three days.

EXTRA

Annex 3 – List of Severe Morbid Events

a) Acute myocardial infarction
b) Cardiac or respiratory failure with at least two of the following concurrent symptoms: - dyspnoea - peripheral oedema - arrhythmia - unstable angina - pulmonary oedema or stasis - hypoxaemia
c) Histologically documented malign neoplasm
d) Complicated diabetes characterized by at least two of the following events: - torpid ulcers - decubitus - neuropathies - peripheral vasculopathies - urogenital infections or superinfections - retinopathy - ketoacidosis - diabetic coma
e) Severe trauma - with or without surgery - involving immobilisation exceeding 40 days. The immobilisation consists in the application of a device that cannot be removed by the patient and/or to prevent loading the limb.
f) Second degree burns covering at least 20% of the body
g) Acute vasculopathy of cerebral ischemic or hemorrhagic nature
h) Multiple sclerosis with significant functional deficit (3-4 on the Expanded Disability Status Scale)
i) Amyotrophic Lateral Sclerosis (ALS)
j) Comatose state
k) Paraplegia and/or Quadriplegia
l) Alzheimer's disease at stage 5 or higher of the Reisberg Scale certified by the UVA (Unità Valutativa Alzheimer) [Alzheimer's Assessment Unit] of a public neurological facility
m) Parkinson's disease at stage three or higher on the Hoehn & Yahr Scale, certified by a public neurological facility
n) Osteomyelitis
o) Severe, post-surgery or post-traumatic infections
p) Severe morbid events that are "similar" by type, event, diagnosis and treatment to those indicated in letters a) to h).

EXTRA

INTESA SANPAOLO
RBM SALUTE

ANNEX 4: List of "TOP" Clinics

ROME

- Casa di Cura Paideia S.p.A.
- Casa di Cura Mater Dei S.p.A.
- Ars Medica
- Villa Benedetta
- Casa di Cura Villa Flaminia
- Casa di Cura Villa Margherita

MILAN

- Istituto Nazionale Tumori
- Istituto Europeo di Oncologia/Monzino
- Casa di cura Columbus
- Humanitas Mirasole S.p.A. (Istituto Clinico Humanitas)
- Casa di Cura Capitanio

TURIN

- Clinica Fornaca di Sessant
- Casa di Cura Sedes Sapientiae
- Casa di Cura Cellini S.p.A.

BERGAMO

- Humanitas Gavazzeni

VARESE

- Istituto Clinico Humanitas Mater Domini Casa di Cura Privata S.p.A.

EXTRA

ANNEX 5: Summary Sheet

The following are the ceilings/sums insured, coinsurance and deductibles for the various options. Unless otherwise indicated, the ceilings are per Year/Family Unit and the coinsurance/deductibles are per event.

HOSPITALISATION	
Surgical/Non-surgical hospitalisation, surgical/non-surgical Same-Day hospitalisation, outpatient surgical procedure, Childbirth/therapeutic abortion, dental surgery, Major Surgery (MS), Transplantation, Post-surgical Rehabilitation, Major Morbid Events (MME)	full list of surgical procedures with ceiling (Int_PLAFONATI), MS and Dental Surgery (Int_ODONTOIATRICI)
Ceiling	€500,000
Conditions:	
In network	100% in case of C-section/therapeutic abortion, natural childbirth, dental surgery, myopia, reconstructive surgery. Deductible of €350 for hospitalisation without surgery, hospitalisation without surgery for post-op rehabilitation, hospitalisation without surgery for SIE and hospitalisation without surgery for long-term hospitalisation. Deductible of: €1,000 for hospitalisation with surgery; €250 for surgical/non-surgical Same-Day Treatment; €150 for Outpatient Surgical Procedure; In case of MS €750 deductible per event. In the event of surgery with surgery, no coinsurance and/or deductible.
Out-of-network, private service at public facility	100% in case of C-section/therapeutic abortion, natural childbirth. Coinsurance: 10%, min. €1,500 per event in case of same-day treatment with surgery, hospitalisation without surgery, hospitalisation without surgery for post-op rehabilitation, hospitalisation without surgery for Serious Health Events, hospitalisation without surgery for long-term hospitalisation. 10% coinsurance with minimum: €1,000 for non-surgical Same-Day Hospitalisation and myopia; 10% coinsurance, min. €1,750 for hospitalisation with surgery; €750 for Outpatient Surgical Procedure). 20% deductible minimum €1,000 in case of dental surgery and reconstructive surgery. in case of MS 15% coinsurance For affiliated structures under direct scheme; for non-affiliated doctors/medical team and/or non-affiliated
Non-surgical hospitalisation	maximum limit of 5 days per hospitalisation and max. 3 hospitalizations per year exclusion if for diagnostic purposes and pre-op diagnosis
Non-surgical hospitalisation for Long-term Care	in cases of hospitalisation lasting over 30 days

EXTRA

C-section/therapeutic abortion (excluding Pre/Post-op)	In the case of C-section requested by the mother, and therefore not as a result of pathologies of the mother or of the unborn child that would make it necessary, the terms and conditions of natural childbirth apply.
Sub-ceiling:	€9,000
Expenses for newborn baby (sub-limit)	€1,000
Obstetric care (sub-limit)	€1,500
Conditions:	100%
Natural childbirth (excluding Pre/Post-op)	
Sub-ceiling:	€6,000
Expenses for newborn baby (sub-limit)	€1,000
Conditions:	100%
Dental surgery	Full list (Int_ODONTOIATRICI)
Sub-ceiling:	€10,000
Conditions:	
In network	100%
Out-of-network, private service at public facility	20% coinsurance, min. €1,000
Myopia	with a difference of more than 4 dioptres (as long as this is not caused by previous corrective surgery) or a visual impairment of one eye of 8 dioptres or more
Conditions:	
In network	100%
Out-of-network, private service at public facility	10% coinsurance, min. €1,000

Reconstructive surgery	mastectomy or quadrantectomy
Ceiling	€5,000
Pre/Post-op	90 days/90 days
Conditions:	
In network	100%
Out-of-network, private service at public facility	20% coinsurance, min. €1,000
Newborns Correction of Congenital Malformations	in the first year of life, increased to the first 10 years of life due to inability to perform surgery in the first year of life
Surgical procedures with ceiling	Full list (Int_PLAFONATI)
Conditions:	100% main procedure, 70% secondary procedures
Limit on hospital stay fee only Out-of-Network	€300 a day; €250 for surgical/non-surgical Same-Day Treatment; not provided for childbirth/therapeutic abortion; in case of hospitalisation for Long-term Care €200 per day for the first 6 months; reduced to €150 for the
Pre/Post-op	100 days/100 days
Post-op physical therapy/rehabilitation treatments	120 days, not provided for natural childbirth, myopia and dental surgery
Fee for accompanying person	€80 per day max 90 days – MS €180 per day max 90 days, not provided for Dental Surgery and Myopia
Nursing Care Limit for non-surgical hospitalisation	€50 a day max 5 days per event; increased to 30 days for post-op rehabilitation and MMEs

Nursing Care for non-surgical Same-Day Treatment, Outpatient Surgical Procedure, Childbirth/Therapeutic Abortion, Dental Surgery	NOT INCLUDED
Transport	€3,000, not provided for outpatient surgical procedure, dental surgery, myopia and National Health System

Indemnity in lieu	
Ceiling	300 days per person/year
Surgical/non-surgical hospitalisation	€100 a day
MS	€120 a day
Surgical/non-surgical Same-Day Treatment	€50 a day
Pre/Post-op	100 days/100 days, 100% (excluding hospitalisation for private service at public facility)
Post-op physical therapy/rehabilitation treatments	100%, 120 days, not provided for natural childbirth, myopia and dental surgery, 100% (excluding hospitalisation for private service at public facility)
SPECIALIST AND/OR OUTPATIENT OUT-OF-HOSPITAL CARE	
Highly Specialised (HS) Care and Diagnostics	Full list (ALTA_D)
Ceiling	€7,500
Conditions:	
In network	€33 deductible per invoice
In network not in direct form	45% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	60% coinsurance, min. €120 per invoice
Out-of-network	30% coinsurance, min. €60 per invoice
Co-pay	100%
Non-invasive prenatal genetic testing on foetal DNA	included in HS ceiling
Routine Diagnostics, Specialist Visits (SV), Physical Therapy and Acupuncture	excluding the examinations provided for in HS and dental and orthodontic examinations not due to accident; including specialist visits/dental and orthodontic examinations due to accident with ER certificate within 48 hours of the event if there are no Emergency Rooms in the place where the accident occurred, the Insured may submit a certificate issued by a substitute public medical facility and drawn up within 48 hours of the event.
Ceiling	€5,500
Conditions:	
In network	€33 deductible per invoice
In network not in direct form	45% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	60% coinsurance, min. €120 per invoice
Out-of-network	30% coinsurance, min. €60 per invoice
Co-pay	100%

EXTRA

Physical therapy	only for accident with ER certificate within 48 hours of the event; cerebral stroke; neoplasms; degenerative and homeoblastic neurological forms (multiple sclerosis, ALS, etc.); neuromyopathic forms: Mixed morbid forms affecting the neuromuscular system; cardiac surgery, thoracic surgery and limb amputation
Conditions:	
In network	€40 deductible per course of treatment
In network not in direct form	30% coinsurance, min. €90 per course of treatment
At TOP Clinics not in direct form	40% coinsurance, min. €120 per course of treatment
Out-of-network	20% coinsurance, min. €60 per course of treatment
Co-pay	100%
Physical therapy at home	
Conditions:	€20.00 per session
Acupuncture	
In-network/out-of-network conditions	20% coinsurance, min. €40 per invoice
Oncological care	services for oncological pathologies for home nursing care, chemotherapy, radiation therapy, other oncological therapies, specialist visits; when this ceiling runs out, those for HS and SV will be used
Ceiling	€12,000
Conditions:	100%
Speech therapy	for accident with an ER certificate within 48 hours of the event or for illness if carried out by a medical specialist or certified speech therapist
Ceiling	€1,000
Conditions:	
In network	€40 deductible per invoice
In network not in direct form	30% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	40% coinsurance, min. €120 per invoice
Out-of-network	20% coinsurance, min. €60 per invoice
Co-pay	100%
Specific learning disorders (SLD)	according to the provisions of DSM -5, provided that the diagnosis is certified by a physician specialised in child neuropsychiatry of the Italian National Health Service
Ceiling	€1,500.00 per family unit/year for moderate or severe cases or up to €500.00 per family unit per year for mild cases
Conditions:	
In network	€40 deductible per invoice
In network not in direct form	30% coinsurance, min. €90 per invoice
At TOP Clinics not in direct form	40% coinsurance, min. €120 per invoice
Out-of-network	20% coinsurance, min. €60 per invoice
Co-pay	100%
Psychotherapy	
Ceiling	€1,500
Conditions:	50% coinsurance

EXTRA

Orthopaedic implants or hearing aids	
Ceiling	€3,000
Conditions:	30% coinsurance, min. €50 per invoice
Dental care due to accidents	with ER certificate within 48 hours of the event
Ceiling	€7,000
Conditions:	100%
Additional services	paediatric visits (up to 14 years)
Ceiling	€1,500, sub-limit €500 per year/person
Conditions:	30% coinsurance
Eyewear	
Ceiling	€400; sub-limit €150 per year/person
Conditions:	100%
Comparative diagnosis	INCLUDED

Maternity package	visits and follow-up exams in the first six months of pregnancy; in case of miscarriage, within 3 months, 1 gynaecological and 3 psychological visits
Ceiling	€500
Conditions:	100%
ANCILLARY BENEFITS AREA	
Emergency Room Care	outpatient services following an accident without hospitalisation; the following benefits are also included with a prescription from the ER: plaster application and removal, diagnostic tests, medical care, medicines and transport
Ceiling	€1,000 per event per year
Treatment of drug addicts	for recovery from drug addiction in therapeutic communities affiliated with the Local Health Unit
Ceiling	€3,000 per person per year, maximum € 30,000 for all Insured
Conditions:	if the total claims of the Assisted parties exceed the amount of € 30,000, the contribution will be divided proportionally among the applicants
Advance on health costs	for MS, maximum 50% of the expense to be incurred within 50% of the Hospitalisation Area ceiling
Nursing care	for terminal illness with appropriate medical/hospital certification
Conditions:	€50 a day up to 90 days
Repatriation of body	in the event of the death of the Insured following admission (including same-day hospital)to a hospital abroad for illness or injury, with or without surgery
Ceiling	€2,000
Conditions:	excluding funeral ceremonies and burial expenses
Home hospitalisation	post-hospitalisation expenses for MS
Ceiling	€15,000, maximum 50 days per hospitalisation
Conditions:	
In network	100%

EXTRA

Out-of-network	10% coinsurance, min. €1,200 per event
Assisted reproductive technology Ceiling Conditions:	 €700 per family unit per year expenses related to the Insured's travel/transfer and any accompanying person's costs if the treatment is carried out abroad are excluded
Post-delivery care Ceiling Conditions:	 Unlimited full list (POST_P), within 1 year of childbirth
Spa treatments for minors Ceiling Conditions:	Unlimited max. 1 course of treatment per year, max. €35.00 per session
Down syndrome (child of Insured) Ceiling Conditions:	 €1,000 a year, max. 5 years for diagnosis of Trisomy 21 in the first 3 years of life
Health Account	INCLUDED
Indemnity for parents in nursing home	for admissions to nursing home of at least 12 consecutive months
Ceiling Conditions:	€350 per year/person in the absence of medical reimbursements during the insurance year
PREVENTION AREA	
Follow-up visits Ceiling Conditions:	At affiliated facilities Unlimited 100% - 1 visit per month per Insured
Flu vaccine Ceiling Conditions:	Out-of-network Unlimited 1 vaccine a year per Insured
Herpes zoster prevention Ceiling Conditions:	At affiliated and non-affiliated facilities Unlimited age > 55 years, deductible €36.15 per service
Paediatric check-up Ceiling Conditions:	At affiliated facilities Unlimited deductible €36.15 per service – as per list, between 6 months and 6 years of age
Nutritional consult and personalised diet Ceiling: In network Out-of-network	1 consult and personalised diet every two years per person Unlimited €80.00 per person for two-year period (€50.00 for the visit and €30.00 for the diet)
Stem cell preservation Ceiling	 €500 per family unit per year

EXTRA

ATTACHMENT 6: POLICY IN RESPECT OF NATURAL PERSONS PURSUANT TO ARTICLES 13 AND 14 OF REGULATION (EU) 679/2016 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL OF 27 APRIL 2016 (HEREINAFTER THE "POLICY") AND CONSENT TO DATA PROCESSING

The Regulation on the "protection of natural persons with regard to the processing of personal data and on the free movement of such data" (hereinafter the "Regulation") contains a series of provisions aimed at ensuring that the processing of personal data is carried out in compliance with the fundamental rights and freedoms of persons. This Policy incorporates the provisions thereof.

SECTION 1 – IDENTITY AND CONTACT DETAILS OF THE DATA CONTROLLER

Intesa Sanpaolo RBM Salute S.p.A., with registered office in Via A. Lazzari n.5, 30174 Venice – Mestre (VE), as the Data Controller (hereinafter also the "Company" or the "Data Controller") processes your personal data (hereinafter the "Personal Data") for the purposes set out in Section 3. For more information please visit the website Intesa Sanpaolo RBM Salute www.intesasanpaolorbmsalute.com and, in particular, the "Privacy" section with all the information regarding the use and processing of Personal Data.

SECTION 2 – CONTACT DETAILS OF THE DATA PROTECTION OFFICER

Intesa Sanpaolo RBM Salute has appointed a "data protection officer" as provided for by the Regulation (also *DPO*). For all matters relating to the processing of your Personal Data and/or to exercise your rights under the Regulation, as listed in Section 7 of this Policy, you may contact the DPO at the following email address: privacy@intesasanpaolorbmsalute.com

SECTION 3 – CATEGORIES OF PERSONAL DATA, PURPOSE AND LEGAL BASIS OF PROCESSING

Categories of Personal Data

The Personal Data that the Company processes are personal data, contact data, data relating to the family unit, policy data, data relating to any claims that concern you, bank data for the settlement of claims, other personal data provided by you, as well as data classified by Article 9.1 of the Regulation as "special categories", such as:

a) Data on health status;
b) data contained in prescriptions and medical reports, invoices from specialists, receipts for the purchase of drugs and medical devices;
c) data relating to insurance services rendered in favour of other Insured Persons, where provided for by the insurance contract.

In addition, within the management of any complaints and disputes, multimedia data (e.g., recordings of telephone calls) may be processed.

Purposes and legal basis for processing:

The Personal Data concerning you, communicated by you to the Company or collected by third parties[1] (in the latter case subject to a check of compliance with the conditions of lawfulness by the third parties), are processed by the Company[i] as part of its activities for the following purposes:

[1] For example, insurance brokers, policyholders of group or individual policies in which you are insured, any jointly obliged parties, other insurance operators (such as agents, insurance brokers, insurance companies, etc.); parties from whom we require information or are required to provide information in order to fulfil your requests (e.g., for issuance or renewal of insurance cover, settlement of

a) Provision of insurance services and/or products requested by you or available for you
As part of the above, your data will be processed in order to provide you with the services and/or products included under any insurance contracts to which you are a party or by pre-contractual measures taken at your request (including the processing of claims for services rendered, administrative checks and health controls, and the settlement of indirect and direct healthcare cases).

In relation to this purpose, the processing of data may be carried out without your consent, as necessary for the execution of the insurance contract to which you are party or pre-contractual measures taken at your request (article 6.1, letter b, of the Regulation).
In relation to this purpose, the processing of particular data (including data suitable for detecting your health conditions and data relating to the health service received) may be carried out only with your consent, the refusal of which may make it impossible for the Company to fulfil the request (article 6.1, letter a of the Regulation).

b) Service communications relating to the relationship between the Data Subject and the Data Controller and notices
Within the scope of this purpose, your data will be processed to facilitate the possible sending of notices and communications between you and the Data Controller, always within the scope of the execution of any insurance contracts. The provision of such data (e.g., e-mail address or telephone number) will be optional.

In relation to this purpose, the processing of data may be carried out without your consent, as necessary for the execution of the insurance contract to which you are party or pre-contractual measures taken at your request (article 6.1, letter b, of the Regulation).

c) Provision of services online or directly via App
As part of this purpose, your data will be processed to allow you to register in the "Reserved Area" of the Data Controller's website and/or access directly through the Apps for mobile devices (FeelUp and Citrus). These data will be used to identify you as our insured, to provide you with the services provided by your policy, to send you the communications necessary for the management of the guaranteed services (also through push notifications, if activated, you may be sent information on the status of your bookings, reminders or appointment confirmations, feedback on the settlement of claims, statements of claims).

In relation to this purpose, data processing may be carried out without your consent, as necessary to allow you to obtain online services through the Reserved Area or App on your smartphone as part of the execution of the insurance contract to which you are party or pre-contractual measures taken at your request (article 6.1, letter b of the Regulation).

d) Fulfilment of legal obligations related to the execution of insurance contracts
As part of this purpose, your data will be processed in order to comply with legal obligations related to the execution of insurance contracts to which you are party, including anti-terrorism, tax, anti-corruption, insurance fraud prevention requirements, to comply with provisions or requests from supervisory and regulatory authorities (e.g., IVASS regulations and the European Insurance Distribution Directive (IDD) require the assessment of the adequacy of the contract offered for the

---

a claim, transfer of benefit position, etc.); associations and consortia in the insurance sector; Judiciary, Law Enforcement and other public entities

entire life of the contract) or, finally, to verify the company's compliance with national and supranational laws and regulations

Your data may also be processed for the management of any complaints (receipt of the complaint, processing, recording in the appropriate register, preparation of the response and sending it).

In relation to this purpose, data processing may be carried out without your consent, as necessary to comply with legal obligations.

e) Extension of the insurance policy in favour of other Insured persons

Within the scope of this purpose, your data and those of your family members will be processed in order to extend the insurance cover to other Insured persons, if provided for by the contract.

In this context, you may be required to provide special categories of data (data disclosing health status, medical reports, etc..) relating to you or your family. This provision of data is necessary to provide you with insurance services, but such data provided may only be processed with your express consent or that of any other Insured concerned, where required by the insurance contract. For the purpose of extending insurance cover to other Insured Persons, if so provided for in the insurance contract, certain data, including data falling within the category of special data, relating to insurance services rendered in their favour, shall be made known to you, where necessary, for the management of the existing policy, as well as for the verification of the relative cover and the limits guaranteed.

f) Business development and insurance risk management of the Company

As part of this purpose, your data will be processed to develop the Company's business and manage risk. Your data may also be transmitted within the Business Group for administrative purposes. In addition, the processing of your Personal Data is necessary in order to:

- manage any disputes;
- pursue any further legitimate interests, including the verification of complaints on a statistical basis and the recording of telephone calls with you. In the latter case, the Company may process your Personal Data only after having informed you and ascertained that the pursuit of its own legitimate interests or those of third parties does not compromise your rights and fundamental freedoms.

In relation to this purpose, data processing is carried out based on the legitimate interest of the Data Controller (article 6.1, letter f) of the Regulation.

SECTION 4 – CATEGORIES OF RECIPIENTS TO WHOM YOUR PERSONAL DATA MAY BE COMMUNICATED

In order to pursue the above purposes, it may be necessary for the Company to disclose your Personal Data to the following categories of recipients:

a) **Companies belonging to the Intesa Sanpaolo Group.**
b) **Third Parties** (companies, freelance professionals, etc.), e.g..:
- Previmedical S.p.A.;
- Mutual Aid Societies;
- Insurance Companies and Brokers;
- Companies that perform audit and certification services;
- Legal departments, in the case of handling complaints and disputes;
- Health funds;
- Healthcare facilities and other affiliated healthcare service providers;
- Companies that perform filing, mail printing, and mail handling services;
- Companies entrusted with the management, settlement and payment of claims;
- Companies providing computer, telematic, financial, administrative or other technical/organisational services);

- Banks

c) **Authorities** (e.g., judicial, administrative, etc.) and public information systems established within public administrations, as well as other entities, such as: IVASS (Istituto per la Vigilanza sulle Assicurazioni - Italian Insurance Oversight Agency); ANIA (National Association of Insurance Undertakings); CONSAP (Concessionaria Servizi Assicurativi Pubblici - Italian Public Insurance Service Concessionaire); FIU (Financial Information Unit); Central Accident Records; CONSOB (Italian National Commission for Companies and the Stock Exchange); COVIP (Commissione di vigilanza sui fondi pensione - Italian Pension Funds Oversight Authority); the Bank of Italy; SIA, CRIF, Ministries; Mandatory social insurance agencies, such as INPS, INPDAI, INPGI, etc. Internal Revenue Service and Tax Registry; Judiciary; Law Enforcement; Equitalia Giustizia, Conciliation bodies pursuant to Legislative Decree no. 28 of 4 March 2010.

The Companies and third parties to whom your Personal Data may be disclosed act as: 1) Data Controllers, i.e., entities that determine the purposes and means of the processing of Personal Data; 2) Data Processors, i.e., entities who process Personal Data on behalf of the Data Controller or 3) Joint Data Processors who jointly determine the purposes and means thereof with the Company or 4) appointed by the Data Controller as authorised entities to process such data.

The Data Controller undertakes to rely solely on entities that provide adequate guarantees regarding data protection, and will appoint them as Data Processors pursuant to article 28 of the Regulation.

SECTION 5 – TRANSFER OF PERSONAL DATA TO A THIRD COUNTRY OR INTERNATIONAL ORGANISATION OUTSIDE THE EUROPEAN UNION

Your Personal Data are processed by the Company within the territory of the European Union and are not disseminated.
If necessary, for technical or operational reasons, the Company reserves the right to transfer your Personal Data to countries outside the European Union for which there are "adequacy" decisions of the European Commission, or based on the adequate safeguards or specific derogations provided for by the Regulation.

SECTION 6 – METHODS OF PROCESSING AND STORING PERSONAL DATA

The processing of your Personal Data is carried out using manual and computerised means and in such a way as to ensure the security and confidentiality of the data.
Your Personal Data is kept for a period of time not exceeding that necessary to achieve the purposes for which they are processed, without prejudice to the retention periods provided for by law. In particular, your Personal Data is generally stored for a period of 10 years from the termination of the contractual relationship to which you are a party; or for 12 months from the issue of the requested quotation in the event that this is not followed by the conclusion of the definitive insurance contract. Personal Data may also be processed for a longer period if an act interrupting and/or suspending the statute of limitations justifies the extension of data storage.

SECTION 7 – RIGHTS OF THE DATA SUBJECT

As a data subject you may exercise, at any time, vis-à-vis the Data Controller the rights provided for by the Regulation listed below, by sending a specific request in writing to the following email address privacy@intesasanpaolorbmsalute.com. You may withdraw at any time the consents expressed with this information in the same way.

Any notices and actions taken by the Company, upon exercise of the rights listed below, will be made free of charge. However, if your requests are manifestly unfounded or excessive, in particular because they are repetitive, the Company may charge you a fee, taking into account the administrative costs incurred, or refuse to meet your requests.

1. Right to access

You may obtain confirmation from the Company as to whether or not any processing of your Personal Data is taking place and, if so, obtain access to the Personal Data and information required by Article 15 of the Regulations, including, without limitation: the purposes of the processing, the categories of Personal Data processed, etc.
If Personal Data is transferred to a third country or international organization, you are entitled to be informed of the existence of adequate safeguards relating to the transfer. If requested, the Company may provide you with a copy of the Personal Data being processed. For any additional copies, the Company may charge you a reasonable fee based on administrative costs. If this request is made by electronic means, and unless otherwise specified, the information will be provided to you by the Company in a commonly used electronic format.

2. Right to rectification

You may obtain from the Company the rectification of your Personal Data which are inaccurate as well as, taking into account the purposes of the processing, the integration thereof, if they are incomplete, by providing a supplementary declaration.

3. Right to erasure

You may obtain from the Data Controller the erasure of your Personal Data, if one of the reasons set forth in article 17 of the Regulation exists, including, by way of example, if the Personal Data is no longer necessary in relation to the purposes for which it was collected or otherwise processed or if you have withdrawn the consent on which the processing of your Personal Data is based and there is no other legal basis for processing.
We inform you that the Company cannot proceed with the erasure of your Personal Data: if their processing is necessary, for example, for the fulfilment of a legal obligation, for reasons of public interest, for the establishment, exercise or defence of legal claims.

4. Right to restriction of processing

You may obtain the restriction of the processing of your Personal Data if one of the cases provided for by article 18 of the Regulation applies, including, for example: if you dispute the accuracy of your Personal Data being processed or if your Personal Data is necessary for the establishment, exercise or defence of legal claims, although the Company no longer needs it for processing purposes.

5. Right to data portability

If the processing of your Personal Data is based on consent or is necessary for the performance of a contract or pre-contractual measures and the processing is carried out by automated means, you may:

- request to receive the Personal Data you provide in a structured, commonly used and machine-readable format (e.g.: computer e/o tablet);
- transmit your Personal Data received to another Data Controller without hindrance from the Company.

You may also request that your Personal Data be transmitted by the Company directly to another data controller designated by you, if this is technically feasible for the Company. In this case, it will be your responsibility to provide us with the exact details of the new data controller to which you intend to transfer your Personal Data, and to provide us with a written authorisation to do so.

6. Right to object

You may object at any time to the processing of your Personal Data if the processing is carried out for the performance of an activity in the public interest or in pursuit of a legitimate interest of the Data Controller (including profiling activity).
Should you decide to exercise the right to object described herein, the Company will refrain from further processing your personal data, unless there are legitimate grounds for processing (grounds overriding the interests, rights and freedoms of the data subject), or the processing is necessary for the establishment, exercise or defence of legal claims.

7. Right to lodge a complaint with the Italian Personal Data Protection Authority

Without prejudice to your right to take action in any other administrative or jurisdictional court, if you believe that the processing of your Personal Data by the Data Controller is in breach of the Regulation and/or the applicable legislation, you may lodge a complaint with the competent Data Protection Authority.

SECTION 8 – PROCESSING OF SPECIAL CATEGORIES OF PERSONAL DATA

In relation to the processing of special categories of personal data (including data relating to the health status and the health service received), used exclusively for the insurance and settlement activities that concern you (e.g., processing claims for reimbursement of health checks carried out), an express manifestation of consent is required, without prejudice to the specific cases provided for by the Regulations which allow the processing of such Personal Data even in the absence of consent.

[i] Last updated on 22 January 2021

INTESA SANPAOLO RBM SALUTE S.p.A.
Registered and Head Office:
Via A. Lazzari no. 5, 30174 Venice – Mestre (VE)
Tel. +39 041 2518798
info@intesasanpaolorbmsalute.com
comunicazioni@pec.intesasanpaolorbmsalute.com

INTESA SANPAOLO RBM SALUTE S.p.A.
Share Capital €160,000,000 fully paid-in - Chamber of Commerce of Treviso TIN and entry in the Companies Register of Treviso-Belluno 05796440963, VAT reg. no. 11991500015, Company registered under no. 1.00161 in the Italian Register of Insurance Companies, authorised to carry out insurance business by ISVAP Order no. 2556 of 17/10/2007 (OJ no. 255 02/11/2007).